SERFF Tracking Number:	*CLTR-125887441*	*State:*	*Arkansas*
Filing Company:	*QBE Insurance Corporation*	*State Tracking Number:*	*41028*
Company Tracking Number:	*BAS-08-1000.00*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.001 Student*
Product Name:	*Blanket Student Medical Insurance*		
Project Name/Number:	*BAS-08-1000.00/BAS-08-1000.00*		

Filing at a Glance

Company: QBE Insurance Corporation

Product Name: Blanket Student Medical Insurance	SERFF Tr Num: CLTR-125887441	State: ArkansasLH
TOI: H04 Health - Blanket Accident/Sickness	SERFF Status: Closed	State Tr Num: 41028
Sub-TOI: H04.001 Student	Co Tr Num: BAS-08-1000.00	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Susan Coulter, Susan Kalmus	Disposition Date: 12/12/2008
	Date Submitted: 12/09/2008	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: BAS-08-1000.00	Status of Filing in Domicile: Not Filed
Project Number: BAS-08-1000.00	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments: NA in PA
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Overall Rate Impact:	Group Market Type: Blanket
Filing Status Changed: 12/12/2008	
State Status Changed: 12/12/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

QBE Insurance Company

NAIC: 39217 FEIN: 22-2311816

Blanket Student Accident and Sickness Insurance Program

Forms:

BAS-08-1000.00 Policy Cover, Table of Contents and Schedule of Affiliates

SERFF Tracking Number:	*CLTR-125887441*	*State:*	*Arkansas*
Filing Company:	*QBE Insurance Corporation*	*State Tracking Number:*	*41028*
Company Tracking Number:	*BAS-08-1000.00*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.001 Student*
Product Name:	*Blanket Student Medical Insurance*		
Project Name/Number:	*BAS-08-1000.00/BAS-08-1000.00*		

BAS-08-1100.04 Schedule of Benefits

BAS-08-1200.04 General Definitions

BAS-08-1300.00 Effective Date, Policy Term, Policy Termination & Renewal

BAS-08-1400.00 Continuous Insurance and Extension of Benefits Provision

BAS-08-1401.00 Managed Care Provisions

BAS-08-2000.04 Accident and Sickness Coverage Provisions

BAS-08-1500.04 General Exclusions

BAS-08-1600.00 General Provisions

BAS-08-1700.00 Coordination of Benefits

BAS-08-1800.00 Appeals Procedure

BAS-08-2200.00 Excess Provisions

AR Notice

Authorization to file

On behalf of QBE Insurance Corporation, we are filing the captioned blanket student medical program for your review and approval. The policy will be issued to colleges and universities in Arkansas for the benefit of eligible students and their dependents.

Students will either enroll for insurance or opt-out of a mandatory insurance plan. There are both a PPO option and an “indemnity” (non-network expense) plan that provides benefits based on the reasonable and customary charges. Mandated benefits are included and are bracketed only to show that they might not be applicable. Examples include benefits that are for dependent children only when dependent coverage is not offered and mandated benefits that apply to sickness only when accident only benefits are provided. Must offer benefits are also shown as bracketed benefits where the policyholder/school will select the must offers.

The list of forms above, beginning with BAS-08-1000.00 and ending with BAS-08-2200.00 are all part of the policy. Each of the sections of the Policy is being filed with its own form number for ease of administration and review. Should changes be required to the forms that trigger a filing, only those affected pages will be filed with the department.

This is a new program for QBE Insurance Corporation and no forms are being replaced by this filing, including the discretionary group currently on file. If you have any questions, please call me at (609) 443-1811 or email me at susank@coulter-and-associates.com. Otherwise we look forward to your approval.

SERFF Tracking Number:	*CLTR-125887441*	*State:*	*Arkansas*
Filing Company:	*QBE Insurance Corporation*	*State Tracking Number:*	*41028*
Company Tracking Number:	*BAS-08-1000.00*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.001 Student*
Product Name:	*Blanket Student Medical Insurance*		
Project Name/Number:	*BAS-08-1000.00/BAS-08-1000.00*		

Company and Contact

Filing Contact Information

(This filing was made by a third party - coulterandassociatesinc)

Susan Kalmus, Consultant	susank@coulter-and-associates.com
C/O Coulter & Associates, Inc	(609) 443-7540 [Phone]
Cranbury, NJ 08512	(609) 443-4103[FAX]

Filing Company Information

QBE Insurance Corporation	CoCode: 39217	State of Domicile: Pennsylvania
Wall Street Plaza	Group Code:	Company Type:
88 Pine Street		
New York City, NY 10005	Group Name:	State ID Number:
(212) 422-1212 ext. [Phone]	FEIN Number: 22-2311816	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
QBE Insurance Corporation	$50.00	12/09/2008	24410239

SERFF Tracking Number:	*CLTR-125887441*	*State:*	*Arkansas*
Filing Company:	*QBE Insurance Corporation*	*State Tracking Number:*	*41028*
Company Tracking Number:	*BAS-08-1000.00*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.001 Student*
Product Name:	*Blanket Student Medical Insurance*		
Project Name/Number:	*BAS-08-1000.00/BAS-08-1000.00*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/12/2008	12/12/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	12/11/2008	12/11/2008	Susan Kalmus	12/12/2008	12/12/2008

SERFF Tracking Number:	*CLTR-125887441*	*State:*	*Arkansas*
Filing Company:	*QBE Insurance Corporation*	*State Tracking Number:*	*41028*
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TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.001 Student*
Product Name:	*Blanket Student Medical Insurance*		
Project Name/Number:	*BAS-08-1000.00/BAS-08-1000.00*		

Disposition

Disposition Date: 12/12/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CLTR-125887441*	*State:*	*Arkansas*
Filing Company:	*QBE Insurance Corporation*	*State Tracking Number:*	*41028*
Company Tracking Number:	*BAS-08-1000.00*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.001 Student*
Product Name:	*Blanket Student Medical Insurance*		
Project Name/Number:	*BAS-08-1000.00/BAS-08-1000.00*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Authorization to File	Approved-Closed	Yes
Form *(revised)*	Blanket Student Accident and Sickness Policy	Approved-Closed	Yes
Form	Blanket Student Accident and Sickness Policy	Replaced	Yes
Form	Application	Approved-Closed	Yes
Form	AR Notice	Approved-Closed	Yes

SERFF Tracking Number:	*CLTR-125887441*	*State:*	*Arkansas*
Filing Company:	*QBE Insurance Corporation*	*State Tracking Number:*	*41028*
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TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.001 Student*
Product Name:	*Blanket Student Medical Insurance*		
Project Name/Number:	*BAS-08-1000.00/BAS-08-1000.00*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	12/11/2008
Submitted Date	12/11/2008
Respond By Date	

Dear Susan Kalmus,

This will acknowledge receipt of the captioned filing.

Objection 1

- Blanket Student Accident and Sickness Policy (Form)

Comment: Please refer to the Child Immunization Expense Benefit under the Schedule of Benefits.

ACA 23-79-141(f)(2)(A) states that Benefits for recommended immunization services shall be exempt from any copayment, coinsurance, deductible, or dollar limit provisions in the accident and health insurance policy. This exemption shall be explicitly stated in the policy.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	12/12/2008
Submitted Date	12/12/2008

Dear Rosalind Minor,

Comments:

Response 1

Comments: Per your objection letter dated 12/11/08 we have corrected the schedule for the Child Immunization Benefit and removed any reference to deductible. We also removed the brackets around the percentage paid to show it will not be variable and will always be 100%. The description of the benefit correctly states it is not subject to the deductible or copayment.

SERFF Tracking Number:	*CLTR-125887441*	*State:*	*Arkansas*
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TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.001 Student*
Product Name:	*Blanket Student Medical Insurance*		
Project Name/Number:	*BAS-08-1000.00/BAS-08-1000.00*		

If you need anything else please let me know, otherwise I look forward to your approval of the filing.

Related Objection 1

Applies To:

- Blanket Student Accident and Sickness Policy (Form)

Comment:

Please refer to the Child Immunization Expense Benefit under the Schedule of Benefits.

ACA 23-79-141(f)(2)(A) states that Benefits for recommended immunization services shall be exempt from any copayment, coinsurance, deductible, or dollar limit provisions in the accident and health insurance policy. This exemption shall be explicitly stated in the policy.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Blanket Student Accident and Sickness Policy	BAS-08-1000.00		Policy/Contract/Fraternal Certificate	Initial		46	AR BAS-08-100000 final 12-12-08.pdf
Previous Version							
Blanket Student Accident and Sickness Policy	*BAS-08-1000.00*		*Policy/Contract/Fraternal Certificate*	*Initial*		*46*	AR BAS-08-100000 Policy Clean.pdf

No Rate/Rule Schedule items changed.

Sincerely,
Susan Coulter, Susan Kalmus

SERFF Tracking Number:	*CLTR-125887441*	*State:*	*Arkansas*
Filing Company:	*QBE Insurance Corporation*	*State Tracking Number:*	*41028*
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TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.001 Student*
Product Name:	*Blanket Student Medical Insurance*		
Project Name/Number:	*BAS-08-1000.00/BAS-08-1000.00*		

Form Schedule

Lead Form Number: BAS-08-1000.00

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	BAS-08-1000.00	Policy/Contract/Fraternal Certificate	Blanket Student Accident and Sickness Policy	Initial		46	AR BAS-08-1000 00 final 12-12-08.pdf
Approved-Closed	BAS-08-5000.00	Application/Enrollment Form	Application	Initial			BAS-08-5000.00.pdf
Approved-Closed	AR Notice	Other	AR Notice	Initial			AR Notice.pdf

QBE INSURANCE CORPORATION

Administrative Office
Wall Street Plaza, 88 Pine Street, 16th Floor
New York, NY 10005

POLICYHOLDER:	{ABC University}
GROUP POLICY NUMBER:	{XXX123456}
POLICY EFFECTIVE DATE:	{January 1, 2009}
POLICY ISSUE DATE:	{January 1, 2009}
include when Policy Term is greater than one year **POLICY ANNIVERSARY DATE:**	{January 1}
POLICY TERM	{January 1, 2009 through December 31, 2009}
STATE OF ISSUE:	{Arkansas}

QBE Insurance Corporation agrees to provide the benefits shown in the Plan of Insurance with respect to each person insured for them under this Policy. The benefits will be paid in accordance with the provisions of this Policy.

This Policy is issued in consideration of: (a) the attached application; and (b) the payment of premiums as set forth herein.

This Policy takes effect as of 12:01 a.m. on its Policy Effective Date, at the Policyholder's address. This Policy terminates at 12:00 a.m. on the day following the last day of the Policy Term if premium is paid according to agreed terms.

The provisions on the pages which follow form a part of this Policy. This Policy is issued at the Administrative Office of Insurance Company in New York .

For Insurance Company

President Secretary

• BLANKET STUDENT ACCIDENT AND SICKNESS POLICY •
• NON-PARTICIPATING •

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

This policy is intended to read in its entirety. In order to understand al the conditions, exclusions and limitations applicable to its benefits, please read all the policy provisions carefully.

Eligible Persons: All full-time students of the Policyholder who {are enrolled for {12} credit hours or more per {semester; quarter}}

Dependents of Insured Students, as defined in the *Definitions* section of this policy

[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Principal Sum	{$1,000 to $25,000}
Loss must occur within	{180 to 365} days of the Covered Accident

Schedule of Covered Losses

Covered Loss	**Benefit**
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of One Hand or Foot and Sight in One Eye	100% of the Principal Sum
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing in Both Ears	50% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum]

PLAN OF INSURANCE

This section will appear if a Policyholder elects a the PPO Plan; otherwise the Indemnity section below will appear.
[Preferred Provider Organization Plan

To locate a Network Provider in Your area, consult Your Provider Directory **[**or call toll free **[**xxx-xxx-xxxx**] [**or visit Our website at **[**##@###.com**]]**.

Benefits will be provided only for the coverages indicated below and will be paid only up to the amounts shown. Benefits are not provided for coverages marked "Nil'.

{Lifetime; Policy Year} Maximum Benefit:
Per Insured Person: {$1,000 - $500,000}

[Per Condition Aggregate Maximum per Injury or Sickness:
Per Insured Person: {$1,000 - $500,000}]

[Per Policy Year Aggregate Maximum per Injury or Sickness:
Per Insured Person: {$1,000 - $500,00}]

[Deductible

applies to:	each {condition, Policy Year}
Network Provider:	{$0 - $150.00} per Insured Student {$0 - $1,000.00} per Insured Dependent
Non-Network Provider	[$250 - $1,000} per Insured Person {$750-$3,000} per Family (3 per family)] {$250 - $1,000} per Insured Student {$250 - $1,000} per Insured Dependent]

[Out-of-Pocket Maximum per Policy Year:

Network Provider:	{$1,000 – unlimited} per Insured Person
Non-Network Provider:	{$1,000 – unlimited} per Insured Person]

[Amount of Insurance { $100-$200 }

COVERAGE	BENEFIT AMOUNT
HOSPITAL EXPENSE BENEFIT	
Hospital Room & Board Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
Miscellaneous Hospital Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]
SURGICAL EXPENSE BENEFITS (INPATIENT OR OUTPATIENT)	
Surgery Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]
Multiple Surgical Procedure Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]
[Anesthesia Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
[Assistant Surgeon Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance up to {20}% of the Surgical Expense paid [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C up to {20}% of the Surgical Expense paid [, subject to Deductible]]
[Second Surgical Opinion Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
IN-HOSPITAL DOCTOR'S FEES AND MEDICAL EXPENSE BENEFIT	
Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]

Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]

OUTPATIENT EXPENSE BENEFIT

[Doctor's Office Visit Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
[Doctor's Office Visit Expense Copayment:	
Network Provider:	{$10 - $25] per visit
Non-Network Provider:	{$50 - $75] per visit]
[Chiropractic Care Office Visit Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
[Chiropractic Care Office Visit Expense Benefit Maximum:	{three (3)} visits per Policy Year]
[Hospital Outpatient Department Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
[Emergency Room Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Copayment:	{$50 - $150} without a referral; { $25 - $7} with a referral
Non-Network Provider:	{70% - 90%} of R & C for a Medical Emergency [, subject to Deductible] {60% - 70%} of R & C for all other [, subject to Deductible] [for visits resulting in a hospital admission]
Copayment:	{$50 - $75} [visits that do not require a hospital admission]]
[Diagnostic X-ray and Laboratory Testing Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
[Physical Therapy Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
[Physical Therapy Expense Benefit Maximum:	{$50.00} per visit, maximum of {$900.00} per Policy Year]
[Occupational Therapy Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
[Occupational Therapy Expense Benefit Maximum:	{$50} per visit, maximum of {$900} per Policy Year The combined maximum benefit for Occupational and Physical Therapy is {$900} per Policy Year]
[Speech Therapy Expense Covered Percentage:	
Network Provider:	{80% - 100} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
[Acupuncture Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
[Acupuncture Expense Benefit Maximum:	{$500} per Policy Year [, subject to Deductible]]
[Immunization Expense Covered Percentage:	{100%} of R & C at the Student Health Center only]

[Allergy Testing and Allergy Extracts Expense Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[High Cost Procedure Expense covered percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
[High Cost Procedure Benefit Maximum:	up to {$1,500} per procedure [, subject to Deductible]]

[MATERNITY EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[OPTIONAL MAMMOGRAPHIC EXAMINATION EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[PELVIC, CERVICAL, PROSTATE AND COLORECTAL EXAM EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[ABORTION EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%] of the Preferred Allowance [, subject to Deductible]]
Non-Network Provider:	{60% - 80%] of R & C [, subject to Deductible]]]

[ACCIDENTAL DENTAL INJURY EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) VACCINE EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

OR

[Copayment	Brand Name Drugs: {$10 - $40} per prescription
Copayment	Generic Drugs: {$5 - $20} per prescription
Benefit Maximum:	{$50} per condition – Plan Maximum
Benefit Maximum:	{$50 per policy year – Plan Maximum**]**

[AMBULANCE EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[CONSULTANT EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[HOME HEALTH CARE EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]
Benefit Maximum:	{100} visits per calendar year]]

[LICENSED NURSE EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[OPTIONAL HOSPICE EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]
Lifetime Benefit Maximum:	{$4,000}]

[PRE-ADMISSION TESTS EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[PRESCRIPTION DRUG EXPENSE BENEFIT

Copayment:	Brand Name Drugs:	{$20} per prescription
	Generic Name Drugs:	{$12} per prescription
Benefit Maximum:		{$3,000}]

[PROSTHETICS APPLIANCE & ORTHOTIC DEVICE EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[SICKNESS DENTAL EXPENSE BENEFIT
Covered Percentage:
Network Provider: {80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider: {60% - 80%} of R & C [, subject to Deductible]]

[SKILLED NURSING FACILITY EXPENSE BENEFIT
Covered Percentage:
Network Provider: {80% - 100} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider: {60% - 80%} of R & C [, subject to Deductible]]

[STUDENT HEALTH CENTER REFERRAL Included]

[EMERGENCY MEDICAL EVACUATION EXPENSE BENEFIT
Covered Percentage: {100%} of actual Expense [, subject to Deductible]]
Benefit Maximum: {$15,000}]

[REPATRIATION OF BODY REMAINS EXPENSE BENEFIT
Covered Percentage: {100%} of actual Expense [, subject to Deductible]
Benefit Maximum: {$15,000}]

[CHILD IMMUNIZATION EXPENSE BENEFIT
Covered Percentage: Network Provider: 100% of the Preferred Allowance
Non-Network Provider: 100% of R & C]

[DENTAL ANESTHESIA AND HOSPITALIZATION EXPENSE BENEFIT
Covered Percentage:
Network Provider: [{80% - 100} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider: {60% - 80%} of R & C [, subject to Deductible]]

[ENTERAL FORMULA EXPENSE BENEFIT
Covered Percentage:
Network Provider: {80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider: {60% - 80%} of R & C [, subject to Deductible]]

[BREAST RECONSTRUCTION AFTER MASTECTOMY EXPENSE BENEFIT
Covered Percentage:
Network Provider: {80% - 100} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider: {60% - 80%} of R & C [, subject to Deductible]]

[NEWBORN HEARING SCREENING EXPENSE BENEFIT
Covered Percentage:
Network Provider: {80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider: {60% - 80] of R & C [, subject to Deductible]]

[OSTEOPOROSIS EXPENSE BENEFIT
Covered Percentage:
Network Provider: {80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider: {60% - 80%} of R & C [, subject to Deductible]]

[OPTIONAL CHILD HEALTH SUPERVISION EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

BREAST CANCER EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]

LOSS/IMPAIRMENT OF SPEECH/HEARING EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]

DIABETES EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]

LEAD POISONING TESTING EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]

[OPTIONAL CHEMICAL DEPENDENCY AND MENTAL ILLNESS EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
Benefit Maximum per Policy Year	{$2,000}

[OPTIONAL ALCOHOLISM TREATMENT EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]
Benefit Maximum per Policy Year	{$6,000}]

[LARYNGECTOMY EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[RECONSTRUCTIVE SURGERY EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[SEVERE MENTAL ILLNESS AND SERIOUS EMOTIONAL DISTURBANCES OF CHILDREN EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[SIGMOIDOSCOPIC EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
Benefit Maximum:	{$3,000}]

[OPTIONAL TEMPOROMANDIBULAR JOINT / CRANIOMANDIBULAR DISORDER EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]
Benefit Maximum:	{$3,000} lifetime maximum]

[TREATMENT OF MORBID OBESITY EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]
Benefit Maximum:	{$3,000} lifetime maximum]

[CLINICAL TRIALS FOR PREVENTION, EARLY DETECTION AND TREATMENT OF CANCER EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]

[ANNUAL ROUTINE EXAM EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%}] of R & C [, subject to Deductible]
Benefit Maximum:	{$150}]

[BREAST IMPLANT REMOVAL EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

INFERTILITY EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]

[MASTECTOMY EXPENSE BENEFIT

Covered Percentage:

Network Provider: {80% - 100%} of the Preferred Allowance [, subject to Deductible]

Non-Network Provider: {60% - 80%} of R & C [, subject to Deductible]]

[PEDIATRIC PREVENTIVE CARE EXPENSE BENEFIT

Covered Percentage:

Network Provider: {80% - 100%} of the Preferred Allowance [, subject to Deductible]

Non-Network Provider: {60% - 80%} of R & C [, subject to Deductible]]

[POST-MASTECTOMY EXPENSE BENEFIT

Covered Percentage:

Network Provider: {80% - 100%} of the Preferred Allowance [, subject to Deductible]

Non-Network Provider: {60% - 80%} of R & C [, subject to Deductible]]

[PROSTATE-SPECIFIC ANTIGEN EXPENSE BENEFIT

Covered Percentage:

Network Provider: {80% - 100%} of the Preferred Allowance [, subject to Deductible]

Non-Network Provider: {60% - 80%} of R & C [, subject to Deductible]]

[CANCER CLINICAL TRIAL EXPENSE BENEFIT

Covered Percentage:

Network Provider: {80% - 100%} of the Preferred Allowance [, subject to Deductible]

Non-Network Provider: {60% - 80%} of R & C [, subject to Deductible]**]**

[DAY SURGERY MISCELLANEOUS EXPENSE BENEFIT

Covered Percentage:

Network Provider: [[80% - 100%] of the Preferred Allowance [, subject to Deductible]]

Non-Network Provider: [[60%- 80%] of R & C [, subject to Deductible]]

[TELEMEDICINE MEDICAL SERVICE BENEFIT

Covered Percentage:

Network Provider: [[80% - 100%] of the Preferred Allowance [, subject to Deductible]]

Non-Network Provider: [[60%- 80%] of R & C [, subject to Deductible]]

PHENYLKETONURIA EXPENSE BENEFIT

Covered Percentage:

Network Provider: [[80% - 100%] of the Preferred Allowance [, subject to Deductible]]

Non-Network Provider: [[60%- 80%] of R & C [, subject to Deductible]]

PREVENTIVE CARE FOR DEPENDENT CHILDREN EXPENSE BENEFIT

Covered Percentage:

Network Provider: [[80% - 100%] of the Preferred Allowance [, subject to Deductible]]

Non-Network Provider: [[60%- 80%] of R & C [, subject to Deductible]]

INDEMNITY PLAN

Benefits will be provided only for the coverages indicated below and will be paid only up to the amounts shown. Benefits are not provided for coverages marked "Nil'.

Lifetime Maximum Benefit:

Per Insured Person:	{$1,000 -$500,000}
[Per Condition Aggregate Maximum per Injury or Sickness:	
Per Insured Person:	{$1,000 - $500,000}]
[Per Policy Year Aggregate Maximum per Injury or Sickness:	
Per Insured Person:	{$1,000 - $500,00}]
[Deductible per Policy Year:	{$100.00} per Insured Person]
[Deductible per [Injury] [or Sickness]:	{$100.00} per Insured Person]
[Amount of Insurance	{ $100-$200 }

COVERAGE	**BENEFIT AMOUNT**
HOSPITAL EXPENSE BENEFIT	
Hospital Room & Board Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} the{0-90%} of R & C]
Benefit Maximum:	**{**$60} per day – Plan Maximum
Miscellaneous Hospital Expense Covered Percentage:	**{**80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
Benefit Maximum:	**{**$100} – Plan Maximum
SURGICAL EXPENSE BENEFITS (INPATIENT OR OUTPATIENT)	
Surgery Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
Benefit Maximum:	**{**$250} – Plan Maximum
Multiple Surgical Procedure Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
[Anesthesia Expense Covered Percentage:	{5%} of Surgical Expense Benefit paid – {100%} of Covered Charges]
[Assistant Surgeon Expense Covered Percentage:	{5%} of Surgical Expense Benefit paid – {100%} of Covered Charges]
[Second Surgical Opinion Expense Covered Percentage:	{5%} of Surgical Expense Benefit paid – {100%} of Covered Charges]
[IN-HOSPITAL DOCTOR'S FEES AND MEDICAL EXPENSE BENEFIT	
Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C
Benefit Maximum:	**{**$10} per visit -- Plan Maximum]
OUTPATIENT EXPENSE BENEFIT	
[Doctor's Office Visit Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[Chiropractic Care Office Visit Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
[Chiropractic Care Office Visit Expense Benefit Maximum:	{$1,000} per Policy Year
[Hospital Outpatient Department Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
[Emergency Room Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
[Diagnostic X-ray and Laboratory Testing Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
[Diagnostic X-ray & Laboratory Testing Expense Copayment in addition to Plan Deductible:	{$0-$20}
[Diagnostic X-ray & Laboratory Testing Expense Benefit Maximum:	Plan Maximum]
[Physical Therapy Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
[Physical Therapy Expense Benefit Maximum:	{$1,000} per Policy Year **[**or {$75} per visit - Plan Maximum**]**
[Physical/Occupational Therapy Expense Maximum Visits:	{two (2) visits – 50 visits}
[Post-Surgical Physical Therapy Expense Benefit Maximum:	{$3,000} per Policy Year
[Occupational Therapy Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90} of R & C]
[Occupational Therapy Expense Benefit Maximum:	{$1,000} per Policy Year [or **{**$75} per visit -- Plan Maximum**]**
[Occupational Therapy Expense Maximum Visits:	{two (2) visits – 50 visits}]
[Speech Therapy Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
[Acupuncture Expense:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
[Immunization Expense Covered Percentage:	{80-100%} of R & C at the Student Health Center only]
[Allergy Testing and Allergy Extracts [Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
[High Cost Procedure Benefit Maximum:	up to {$1,500} per procedure]

[MATERNITY EXPENSE BENEFIT
Covered Percentage: **{**80-100%} of R & C [up to the first {0-$5,000}; then {0-90%} of R & C]

[OPTIONAL MAMMOGRAPHIC EXAMINATION EXPENSE BENEFIT
Covered Percentage: **{**80-100%} of R & C [up to the first {0-$5,000} then {0-90} of R & C]

[PELVIC, CERVICAL, PROSTATE AND COLORECTAL EXAM EXPENSE BENEFIT
Covered Percentage: **{**80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[ABORTION EXPENSE BENEFIT {80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) VACCINE EXPENSE BENEFIT
Covered Percentage: {80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R& C]; *or*
Copayment Brand Name Drugs:
{$10 - $40} per prescription

Copayment	Generic Drugs: {**[**$5 - $20} per prescription
Benefit Maximum:	{$50} per condition – Plan Maximum
Benefit Maximum:	{$50} per policy year – Plan Maximum**]**

[ACCIDENTAL DENTAL INJURY EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]; *or* {$75} per tooth – Plan Maximum

[AMBULANCE EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[CONSULTANT EXPENSE BENEFIT

Covered Percentage:	**{**80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[HOME HEALTH CARE EXPENSE BENEFIT

Covered Percentage:	**{**80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
Benefit Maximum:	{100} visits per calendar year

[LICENSED NURSE EXPENSE BENEFIT	**{**80-100%] of R & C [up to the first [0-$5,000] then [0-90%] of R & C]
[OPTIONAL HOSPICE EXPENSE BENEFIT	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]]

[PRE-ADMISSION TESTS EXPENSE BENEFIT

Covered Percentage:	**{**80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[PRESCRIPTION DRUG EXPENSE BENEFIT

Covered Percentage:		{90%} at the Student Health Center {80%} of R &C elsewhere
Copayment	Brand Name Drugs:	{$100 - $40} per prescription
Copayment	Generic Drugs:	{$5 - $20 per prescription}
Benefit Maximum:		{$50 - Plan Maximum}]

[PROSTHETICS APPLIANCE & ORTHOTIC DEVICE EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]]

[SICKNESS DENTAL EXPENSE BENEFIT	{80-100%} of R & C [up to the first {0-$5,00} then {0-90%} of R & C]]

[SKILLED NURSING FACILITY EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[STUDENT HEALTH CENTER REFERRAL	Included]

[EMERGENCY MEDICAL EVACUATION EXPENSE BENEFIT

Covered Percentage:	{100%} of actual Expense
Benefit Maximum:	{$50,000}]

[REPATRIATION OF BODY REMAINS EXPENSE BENEFIT

Covered Percentage:	{100%} of actual Expense
Benefit Maximum:	{$25,000}]

[CHILD IMMUNIZATION EXPENSE BENEFIT

Covered Percentage:	100% of R & C]

[DENTAL ANESTHESIA AND HOSPITALIZATION EXPENSE BENEFIT

Covered Percentage:	{0-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[ENTERAL FORMULA EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {10-90%} of R & C]

[BREAST RECONSTRUCTION AFTER MASTECTOMY EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[NEWBORN HEARING SCREENING EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]]

[OSTEOPOROSIS EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]]

[OPTIONAL CHILD HEALTH SUPERVISION EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]]

BREAST CANCER EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

LOSS/IMPAIRMENT OF SPEECH/HEARING EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

DIABETES EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

LEAD POISONING TESTING EXPENSE BENEFIT

Covered Percentage:	{80-100%] of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[OPTIONAL CHEMICAL DEPENDENCY AND MENTAL ILLNESS EXPENSE BENEFIT

Covered Percentage:	{80%} of R & C
Benefit Maximum per Policy Year	{2,000}]

[OPTIONAL ALCOHOLISM TREATMENT EXPENSE BENEFIT

Covered Percentage:	{80} of R & C
Benefit Maximum per Policy Year	{$6,000}]

[LARYNGECTOMY EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]]

[RECONSTRUCTIVE SURGERY EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]]

[SEVERE MENTAL ILLNESS AND SERIOUS EMOTIONAL DISTURBANCES OF CHILDREN EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[SIGMOIDOSCOPIC EXPENSE BENEFIT

Covered Percentage:	{100%} of actual Expense
Benefit Maximum:	{$3,000}]

[TEMPOROMANDIBULAR JOINT / CRANIOMANDIBULAR DISORDER EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
Benefit Maximum:	{$3,000} lifetime maximum]

[TREATMENT OF MORBID OBESITY EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of [R & C]
Benefit Maximum:	{$3,000} lifetime maximum]

[CLINICAL TRIALS FOR PREVENTION, EARLY DETECTION AND TREATMENT OF CANCER EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
Benefit Maximum:	{$3,000}]

[ANNUAL ROUTINE EXAM EXPENSE BENEFIT

Covered Percentage:	{100%} of actual Expense
Benefit Maximum:	{$150}]

[BREAST IMPLANT REMOVAL EXPENSE BENEFIT

Covered Percentage:	**{**80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

INFERTILITY EXPENSE BENEFIT

Covered Percentage:	**{**80-100%} of R & C [up to the first {0-$5,00} then {0-90%} of R & C]

[MASTECTOMY EXPENSE BENEFIT

Covered Percentage:	**{**80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[PEDIATRIC PREVENTIVE CARE EXPENSE BENEFIT
Covered Percentage: {80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[POST-MASTECTOMY EXPENSE BENEFIT
Covered Percentage: {80-100%} of R & C [up to the first {0-$5,00} then {0-90} of R & C]

[PROSTATE-SPECIFIC ANTIGEN EXPENSE BENEFIT
Covered Percentage: {80-100%} of R & C [up to the first {0-$5,000} then{0-90%} of R & C]

[CANCER CLINICAL TRIAL EXPENSE BENEFIT
Covered Percentage: {80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[DAY SURGERY MISCELLANEOUS EXPENSE BENEFIT
Covered Percentage: {80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[TELEMEDICINE MEDICAL SERVICE BENEFIT
Covered Percentage: {80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

PHENYLKETONURIA EXPENSE BENEFIT
Covered Percentage: {80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

PREVENTIVE CARE FOR DEPENDENT CHILDREN EXPENSE BENEFIT
Covered Percentage: {80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

SCHEDULE OF PREMIUM RATES

CLASS OF INSURED PERSONS	TERM OF COVERAGE	PREMIUM RATE
[Student Only	Annual	$
Spouse Only	Annual	$
Child(ren) Only	Annual	$
Student Only	Fall	$
Spouse Only	Fall	$
Child(ren) Only	Fall	$
Student Only	Spring	$

Spouse Only	Spring	$
Child(ren) Only	Spring	$
Student Only	Summer	$
Spouse Only	Summer	$
Child(ren) Only	Summer	$

GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

Accident means a specific unforeseen event which happens while the Insured Person is covered under this Policy and which, directly and from no other cause, results in an Injury.

[Allowed Application Period means a period of [15] days after the Policy Effective Date or for those students who start mid year, [15] days from the start of the [quarter] during which an eligible student may enroll and be covered as of the Policy Effective Date or the start of the [quarter], respectively.]

Application means any enrollment form required by the Policyholder for coverage under this Policy.

[Benefit Period means the [12 months**]** immediately following the date of the Accident or first treatment of a Sickness.**]**

Coinsurance means the percentage of Reasonable and Customary Expenses for which the Insured Person is responsible for a covered service.

Complications of Pregnancy means conditions which require Hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:

- acute nephritis or nephrosis; and
- cardiac decompensation or missed abortion; and
- similar medical and surgical conditions of comparable severity; and
- non-elective caesarean section; and
- termination of an ectopic pregnancy; and
- spontaneous termination when a live birth is not possible. (This does not include elective abortion.)

Not included are: (a) false labor, occasional spotting or doctor prescribed rest during the period of pregnancy; (b) morning sickness; (c) hyperemesis gravidarum and preeclampsia; and (d) similar conditions not medically distinct from a difficult pregnancy.

Copayment means the specified dollar amount an Insured Person must pay for specified charges. The copayment is separate from and not a part of the Deductible or Coinsurance.

Covered Charge or Covered Expense as used herein means those charges for any treatment, services or supplies that are: (a) for Network Providers, not in excess of the Preferred Allowance; (b) for Non-Network Providers, not in excess of the Reasonable and Customary Expenses; (c) not in excess of the charges that would have been made in the absence of this insurance; and (d) incurred while this Policy is in force as to the Insured Person except with respect to any expense payable under the Extension of Benefits Provision.

Covered Percentage means that part of the Covered Charge that is payable by the Company after the Deductible or Copayment has been met.

[Deductible means the amount of Expenses for covered services and supplies which must be incurred by the Insured Person before specified benefits become payable**.**]

[Dependent means: (a) the Insured Student's spouse **[**residing with the Insured Student] [or Domestic Partner residing with the Insured Student]; or (b) the Insured Student's unmarried children under the age of 25. Children must be fully supported by the Insured Student. Coverage for newborn children will consist of coverage for Sickness or Accident, including routine newborn care and the necessary care or treatment of congenital defects, birth abnormalities, or premature birth. Such coverage will start from the moment of birth, if the Insured Student is already insured for dependent coverage when the child is born. If the Insured Student does not have dependent coverage when the child is born, We cover the newborn child for dependent benefits from and

after the moment of birth. To continue the newborn child's dependent benefits past the first 90 days, the Insured Student must notify Us in writing within 90 days of the child's birth.

If payment of a specific premium is required to provide coverage for a child, such premium must be paid within 90 days after the date of birth in order to have the coverage continue beyond such 90 day period. If an application or other form of enrollment is required in order to continue coverage beyond the 90 period after the date of birth and the Student has notified Us of the birth within such 90 day period, We will, upon notification, provide the Student with all forms and instructions necessary to enroll the newly born child and We will allow the Student an additional ten days from the date the forms and instructions are provided in which to enroll the newly born child.

The term children includes an Insured Student's biological children and step-children who depend on the Insured Student for their full support.

Adopted children of the Insured Student are covered on the same basis as other Dependent children: (a) from the date of birth if a petition for adoption is filed within 60 days of the birth of such child; or (b) from the date of Placement for the purpose of adoption if a petition for adoption is filed within 60 days of Placement of such child. Such coverage shall continue unless the Placement is disrupted prior to legal adoption and the child is removed from Placement. Coverage shall include the necessary care and treatment of medical conditions existing prior to the date of Placement. As used here, Placement means in the physical custody of the adoptive Insured Student.

A child's coverage will not end because the child has reached the age limit shown above, if he or she: (a) is not able to earn his or her own living as a result of mental or physical handicap; and (b) became so handicapped before reaching the age limit; and (c) is chiefly dependent on the Insured Student for support and maintenance.

The Insured Student must send us proof of the child's dependency or handicap whenever requested. This will be at Our Expense. If the incapacity or dependency is thereafter removed or terminated. You must notify us.

[Any Dependent on active duty in any military, naval, or air force of any country is not eligible for coverage under this Policy.]]

Doctor as used herein means: (a) a legally qualified physician licensed by the state in which he or she practices; or (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of residence of such practitioner; or (c) a certified nurse midwife while acting within the scope of that certification.

[Domestic Partner means the same sex partner of an Insured Student who has filed a "Declaration of Domestic Partnership" with the Policyholder's administrative offices and who: (a) has been residing with the Insured Student for at least 12 consecutive months, and intends to do so indefinitely; (b) is considered the Insured Student's "sole Domestic Partner"; (c) is, along with the Insured Student, at least 18 years of age; (d) is, along with the Insured Student, jointly responsible for each other's welfare and financial obligations; and (e) is, along with the Insured Student, not married or related by blood.**]**

[Domestic Student is a student classified as a United States Citizen or eligible Non-Citizen (Permanent Resident or Refugee).**]**

Effective Date means the first date a student becomes covered under the Policy.

Elective Treatment means medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Insured Person's Effective Date of coverage.

Elective Treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction; breast implants; sexual reassignment surgery; impotence (organic or otherwise); submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered chronic purulent sinusitis; treatment for weight reduction; learning disabilities; immunizations; treatment of infertility and routine physical examinations.**]**

[Experimental or Investigational Care means a service or supply:
(a) that We, in Our discretion, determine is not commonly and customarily recognized as being safe and effective for the particular diagnosis or treatment; or
(b) which requires approval by any governmental authority and such approval has not been granted before the service or supply is furnished.

We may rely upon the advice of medical consultants and commonly recognized national medical organizations in determining which services or supplies are experimental or investigational.**]**

Hospital means a facility which meets all of these tests:
(a) it provides inpatient services for the care and treatment of injured and sick people; and
(b) it provides room and board services and nursing services 24 hours a day; and
(c) it has established facilities for diagnosis and surgery; and
(d) it is supervised by a Doctor; and
(e) it is run as a Hospital under the laws of the jurisdiction in which it is located.

Hospital does not include a place run mainly: (a) for alcoholics or drug addicts; (b) as a convalescent home; (c) as a nursing or rest home; or (d) as a hospice facility.

Hospital Confinement means a stay of 18 or more consecutive hours as a resident bed-patient in a Hospital.

Injury means bodily injury caused by an Accident which is the sole cause of the Loss. All injuries due to the same or a related cause are considered one Injury.

Insured Person means an Insured Student **[**and his or her covered Dependent(s)**]** while insured under this Policy.

Insured Student means a student of the Policyholder who is eligible and insured for coverage under this Policy.

[International Student is a student classified as a Non-Immigrant. For example, students holding visa types: "F" (Student), "J" (Exchange Visitor), "B" (Tourist), or "A" (Diplomat).**]**

[Lifetime Aggregate Maximum means the total amount of benefits payable for all Injuries and Sicknesses combined under this Student Health Insurance Policy or Policies issued to the Policyholder with respect to the Policyholder immediately before this Policy.**]**

Loss means medical expense covered by this Policy as a result of Injury or Sickness as defined in this Policy, and other expenses as specifically covered.

Medical Emergency means the sudden and, at the time, unexpected onset of an Injury [or Sickness] that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but is not limited to:

(a) placing the person's health in significant jeopardy;
(b) serious impairment to a bodily function;
(c) serious dysfunction of any bodily organ or part;
(d) inadequately controlled pain; or
(e) with respect to a pregnant woman if she is having contractions:
    1. that there is inadequate time to effect to safe transfer to another Hospital before delivery; or
    2. that transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

Medically Necessary means that a service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice. A service or supply will not be considered as Medically Necessary if:
(a) it is provided only as a convenience to the Insured Person or provider;
(b) it is not the appropriate treatment for the Insured Person's diagnosis or symptoms;

(c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

The fact that any particular Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

[Network Providers are Doctors, Hospitals and other healthcare providers who have contracted to provide specific medical care at negotiated prices.**]**

[Non-Network Providers have not agreed to any pre-arranged fee schedules.**]**

[Out-of-Pocket Maximum means the maximum dollar amount an Insured Person is responsible to pay during a Policy Year. After an Insured Person has reached the Out-of-Pocket Maximum, We cover most benefits at 100% for the remainder of the Policy Year. Some benefits, however, will always remain payable at the percentage shown in the Plan of Insurance. The Out-of-Pocket Maximum is met by accumulated Deductible [and] Coinsurance [and Copayments *or* Co-payments are not applied to the Out-of-Pocket maximum.]. Penalties and amounts above the Reasonable and Customary Expense do not count toward the Out-of-Pocket Maximum. The Out-of-Pocket Maximum is shown in the Plan of Insurance.**]**

[Per Condition Aggregate Maximum means the total amount of benefits payable for each Injury or Sickness under this Student Health Insurance Policy or Policies issued to the Policyholder with respect to the Policyholder immediately before this Policy.**]**

Policy Effective Date means the date the Policy takes effect as shown in the Plan of Insurance.

[Policy Termination Date means the last day of the policy term shown on the first page of the policy.**]**

Policyholder means the institution indicated on the face page of this Policy.

Policy Year means the 12 month period beginning on the Policy Effective Date.

Pre-Existing Condition means any injury sustained in an accident that occurred, or a sickness that first manifested itself, before the Insured Person's effective date of coverage under this Policy and for which the Insured Person has not received any diagnosis, medical advice, care or treatment within the 6-month period immediately preceding his effective date of coverage. A pregnancy that existed on an Insured Person's effective date will not be considered Pre-Existing Condition.

Benefits for a Pre-Existing Condition may be limited. Please read the *General Exclusions and Limitations* section for any applicable limitations.

[Preferred Allowance means the amount a Network Provider will accept as payment in full for Covered Charges.**]**

Reasonable and Customary Expenses means fees and prices generally charged within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.

Sickness means sickness or disease which is the sole cause of the Loss. Sickness includes both normal pregnancy and Complications of Pregnancy. All sicknesses due to the same or a related cause are considered one Sickness.

We, Us and **Our** mean QBE Insurance Corporation, domiciled in Pennsylvania.

You and **Your** mean the Insured Person.

EFFECTIVE DATE, POLICY TERM, POLICY TERMINATION & RENEWAL

This Policy takes effect as of the Policy Effective Date stated in the Plan of Insurance. It continues in force until the Policy Termination Date. Subject to Our consent, this Policy may be renewed for like periods by the payment, within the Grace Period provided in the General Provisions Section, of the renewal premium at the premium rate then in force. We reserve the right to adjust the premium rate on the first anniversary of the Policy Effective Date. We will give the Policyholder at least {60} days prior written notice. We also reserve the right to refuse to renew this Policy.

However, in no event will We refuse to renew or cancel this Policy during any term for which premium has been paid.

EFFECTIVE DATE AND TERMINATION DATE OF INDIVIDUAL COVERAGE

EFFECTIVE DATE OF INSURED PERSON'S COVERAGE

The insurance of each Eligible Student shall take effect as follows:

[[(a) If an Eligible Student enrolls and pays any required premium on or before the Policy Effective Date, coverage will begin on the Policy Effective date;]
[(b) If an Eligible Student enrolls and pays any required premium after the Policy Effective Date but within the Allowed Application Period, coverage will begin on the Policy Effective Date or the start of the term or semester in which the student has enrolled;]
[(c) If an Eligible Student enrolls and pays any required premium] after the Allowed Application Period, coverage will begin on the day after the enrollment card and premium is received; or]
[(d) If an Eligible Student enrolls and pays any required premium on or before the Policy Effective Date and such student is a participant in intercollegiate sports or a school sponsored activity or requirement, coverage will begin on the date the eligible student is required to be on campus.]]

LATE ENROLLMENT FOR DEPENDENTS

An Eligible Student may add his or her Dependent as a late enrollee:
[(a) when he or she marries. The application for coverage must be submitted within 31 days of the date of marriage. Coverage will be effective on the date of the marriage. Payment for the full semester or pro-rated premium for the remainder of the semester, is required even if the spouse is enrolled after the term has begun;]
[(b) when he or she provides a signed affidavit of Domestic Partnership. Proof of Domestic Partnership may be required. Payment for the full semester or pro-rated premium for the remainder of the semester, is required even if the Domestic Partner is enrolled after the term has begun;]
[(c) when he or she acquires a Dependent child through birth, adoption or guardianship decree. The application must be submitted within 31 days of the date the child is born, adopted or acquired through decree. Coverage will be effective as of the date of birth, adoption or guardianship. Payment for the full semester or pro-rated premium for the remainder of the semester, is required even if the Dependent child is enrolled after the term has begun; and]
[(d) when his or her Dependent arrives from a foreign homeland. The application for coverage must be submitted within 31 days of the date of the Dependent's arrival from the foreign homeland. Coverage will be effective as of the date of the Dependent's arrival following direct travel from the homeland. Payment for the full semester or pro-rated premium for the remainder of the semester, is required even if the Dependent is enrolled after the term has begun.;]

[If the Eligible Student does not add a new Dependent within 31 days of the date the Dependent becomes eligible for coverage, he or she must wait until the following school term to add the Dependent for coverage.]

TERMINATION DATE OF INSURED PERSON'S COVERAGE

The insurance for an Insured Person shall terminate on the first of the following dates:
[[(a) on the date this Policy is terminated;] or
[(b) on the premium due date if the required premium for the Insured Person is not paid, except as a result of inadvertent error;] or

[(c) as of the date the Insured Person enters military service, in which case a pro-rata refund of premium will be made to such Insured Person;] or

[(d) on the date the Insured Person no longer qualifies under the Description of Class as shown in the Schedule of Eligible Classes;] or

[(e) on the last day the Insured Student is required to be on campus at the Policyholder or, if the Policyholder has so elected, the anniversary of the Policyholder's Policy.]]

Termination of Insurance for an Insured Person shall be without prejudice to any claim which starts prior thereto.

[If a student loses eligibility under this Policy because he or she no longer qualifies under the terms described in the Master Policy, he or she may apply for continuation of coverage. The application must be made within 31 days of losing eligibility, and the applicable premium must be paid.]

RENEWABILITY OF COVERAGE

A student who is enrolled as a regular undergraduate or graduate student at the College or University will be provided with continuous coverage under this Policy for himself or herself and his or her Insured Dependents each subsequent year the Policyholder renews this Policy with Us. Once an Insured Person has been covered under this Policy and satisfied any Pre-existing Condition Limitation exclusion period, if applicable, coverage under this Policy will be considered continuous. The student must apply for coverage and pay premiums as described in the Policy.

CONTINUOUS INSURANCE AND EXTENSION OF BENEFITS PROVISIONS

Continuous Insurance This Policy may be replacing a Prior Plan with another insurer.

Prior Plan means the Student Health Insurance policy or policies issued to the Policyholder with respect to the Policyholder immediately before the current Policy.

Injury or **Sickness** shall include an Injury sustained, or a Sickness first manifesting itself, while the Insured Person is continuously insured under the Prior Plan and became insured under this Policy without a break in coverage.

But no benefits shall be payable for such Injury or Sickness to the extent that such benefits are payable under the Prior Plan for the same expenses. This will apply even though the Prior Plan provided that it will not duplicate the benefits under another Policy.

Also, the total amount of benefits payable for Injury or Sickness under this Policy and the Prior Plan cannot exceed the [Lifetime Aggregate Maximum] [or the Per Condition Aggregate Maximum].

Nothing contained herein shall be held to vary, alter, waive, or extend any of the provisions, exclusions, and other terms of this Policy, except as provided above.]

Extension of Benefits

If an Insured Person is confined to a Hospital on the date his or her insurance terminates, charges incurred during the continuation of that Hospital Confinement shall also be included in the term Expense, but only up to the limit of liability otherwise imposed under the Policy for the sickness or injury causing the hospital confinement.

[MANAGED CARE PROVISIONS *This section will appear if a Policyholder elects a the PPO Plan*

This Policy provides benefits based on the type of health care provider the Insured Person or his or her Dependent selects. This Policy provides access to both Network Providers and worldwide coverage for Non-Network Providers.

This Policy will pay the Covered Percentage of the Preferred Allowance for Covered Charges if the Insured Person or his or her Dependent uses a Network Provider. This Policy will pay the Covered Percentage of the Reasonable and Customary Expense for Covered Charges if a Non-Network Provider is used. All payments will be subject to any applicable Deductible, Coinsurance, Maximum Benefits, and other provisions or limitations in this Policy. Eligible Expenses are payable in accordance with the "Section I: Plan of Insurance". The [Lifetime Aggregate Maximum] [or Per Condition Aggregate Maximum] for all Covered Charges is {$500,000} per Insured Person.

Use of Network Providers offers better benefits for the Insured Person. Non-Network Provider services are subject to the Deductible and higher Coinsurance. Refer to the Plan of Insurance for a complete description of coverage.

The Insured Person should be aware that Network Provider Hospitals may be staffed with Non-Network Providers. Receiving services from a Network Provider does not guarantee that all charges will be paid at the Network Provider level of benefits.

It is important that the Insured Person verify that his or her Doctors are Network Providers each time he or she calls for an appointment or at the time of service.

[DEDUCTIBLE, COINSURANCE AND COPAYMENT RULES

[DEDUCTIBLE The Insured Person's Deductible applies to all **[**Network and**]** Non-Network Provider Covered Charges unless specified otherwise in this Policy.]

[Deductible Carry Over - Any eligible expenses incurred during the last {three 3}) months of the benefit period and credited to the Deductible for that Policy Year will be applied toward the next year's Deductible.]

[Common Accident - If two or more family members are hurt in the same Accident, only one Deductible needs to be satisfied among them for Expenses relating to the Accident. This special feature applies to eligible Expenses each Policy Year for the same Accident**.]**

[COINSURANCE/COPAYMENTS Some covered services are subject to Coinsurance and Copayments. This is the amount the Insured Person must pay to the Doctor or Hospital for each procedure, visit or confinement each time he or she receives a covered service, including prescription drugs. The Coinsurance is not applied until after the Insured Person has paid any applicable Deductible that may be required under this Policy. What We pay is shown in the Plan of Insurance. The Coinsurance and Copayments, whether from a Network or a Non-Network Provider, apply toward the Out-of-Pocket Maximum.

Covered services which are rendered by a Network Provider and subject to a Copayment will not be subject to the Deductible.]]

[OUT OF POCKET MAXIMUM The Out-of-Pocket Maximum applies to covered services rendered by a Network Provider and Non-Network Provider. Once the Insured Person reaches the Out-of-Pocket Maximum shown in the Plan of Insurance, eligible Expenses will be paid at 100% of Covered Charges for the remainder of the Policy Year or until he or she reaches the [Lifetime Aggregate Maximum] [or Per Condition Aggregate Maximum] as outlined in the Plan of Insurance, whichever occurs first. The Out-of-Pocket Maximum is met by accumulated [Deductible], [Coinsurance] and [Copayments].]

[WAIVER OF COPAYMENT The Emergency Room Copayment will be waived if the Insured Person is admitted to the Hospital immediately following emergency room treatment. The admission must be for the same condition for which the Insured Person received Medical Emergency care**.]]**

ACCIDENT AND SICKNESS COVERAGE PROVISIONS

All benefits to this Policy are shown in the Plan of Insurance. The benefits are described on the pages attached to and made a part of this Policy.

[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

We will pay the benefit for any one of the Covered Losses listed in the *Schedule of Benefits,* if a Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident within the applicable time period specified in the *Schedule of Benefits.*

Loss of hands and feet means the loss at or above the wrist or ankle joints. Loss of eyes means total irrecoverable loss of the entire sight. **[**Loss with regards to thumb and index finger means severance through or above metacarpophalangeal joints.**]**

Only one of the amounts named above will be paid for Injuries resulting from any one Accident. The amount so paid shall be the largest amount that applies.

This provision does not cover the Loss if it in any way results from or is caused or contributed:

(1) By physical or mental illness; medical or surgical treatment except treatment that results directly from a surgical operation made necessary solely by an Injury covered by the Policy;

(2) By an infection, unless it is caused solely and independently by a covered Accident or if it is a bacterial infection resulting from the accidental ingestion of contaminated substances;

(3) **[**For Expenses for which a contributing cause was the Insured Person's commission of, or attempt to commit a felony, or for which an Insured Person's engagement in an illegal occupation was the contributing cause; or**]**

(4) **[**While the Insured Person is legally intoxicated or under the influence of any drug unless taken as prescribed by a Doctor.**]**

In addition to the above, this provision is subject to the Exclusions as provided.**]**

ACCIDENT EXPENSE BENEFIT

When, by reason of Injury, an Insured Person incurs expenses for hospital, surgical or medical treatment, services or supplies, We will pay the Covered Percentage of the Covered Charges incurred [within 52 weeks from the date of Accident] as shown in the Plan of Insurance. Benefits are paid in accordance with the schedule shown for the Accident Expense Benefits in the Plan of Insurance. When an Insured Person incurs expenses for dental treatment for Injury to sound natural teeth, We will pay for the Covered Percentage of the Covered Charges incurred [within 52 weeks of the date of the Accident], as shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.

[SICKNESS EXPENSE BENEFIT *program may be offered on accident only or accident and sickness basis. Deleted when accident only*

When, by reason of Sickness, an Insured Person incurs expenses for hospital, surgical or medical treatment, services or supplies, We will pay for the Covered Percentage of the Covered Charges covered by the Sickness Expense Benefit Provisions incurred [within 52 weeks from the date of the first medical treatment for the Sickness] as shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.

Charges that are not covered for Accident & Sickness Expense Benefits

Charges to buy or rent:
- Air conditioners;

- Air purifiers;
- Motorized transportation equipment;
- Escalators or elevators in private homes;
- Eye glass frames or lenses, hearing aids;
- Swimming pools or supplies for them;
- General exercise equipment.]

HOSPITAL EXPENSE BENEFIT

Part A **Hospital Room and Board Expense**

When, by reason of Injury or Sickness, an Insured Person requires Hospital Confinement, We will pay the Covered Percentage of the Hospital room and board Covered Charge for a semi-private room containing two or more beds including meals, special diets and nursing services incurred for the period of such Hospital Confinement. Coverage includes a bed in a newborn nursery, special care, or intensive care unit.

Part B **Miscellaneous Hospital Expense**

[Miscellaneous Hospital Expense includes expenses incurred for:

(a) anesthesia, anesthesia supplies and services;
(b) operating, delivery and treatment rooms and equipment;
(c) diagnostic x-ray and laboratory tests;
(d) lab studies;
(e) oxygen tent;
(f) blood and blood services;
(g) prescribed drugs and medicines;
(h) medical and surgical dressings, supplies, casts and splints;
(i) radiation therapy, intravenous chemotherapy, kidney dialysis, and inhalation therapy;
(j) chemotherapy treatment with radioactive substances;
(k) intravenous injections and solutions, and their administration;
(l) physical and occupational therapy; and
(m) other necessary and prescribed Hospital expenses.**]**

We will pay the Covered Percentage of the Covered Charge incurred by the Insured Person during the period of Hospital Confinement or for a Surgical Procedure performed on an outpatient basis.

What We pay is shown in the Plan of Insurance.

SURGICAL EXPENSE BENEFIT

Part A **Surgery Expense Benefit**

When, by reason of Injury or Sickness, an Insured Person requires surgery on an inpatient or outpatient basis, We will pay the Covered Percentage of the Covered Charges of the Surgical Expense, in connection with any one Surgical Procedure, subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.

Definitions

Surgical Expense means charges by a Doctor for:
(a) a Surgical Procedure;
(b) necessary preoperative treatment during a Hospital stay in connection with such procedure; and
(c) usual post-operative treatment.

Surgical Procedure means:
(a) a cutting procedure;
(b) suturing of a wound;

(c) treatment of a fracture;
(d) reduction of a dislocation;
(e) radiotherapy;
(f) electrocauterization;
(g) diagnostic and therapeutic endoscopic procedures;
(h) injection treatment for hemorrhoids and varicose veins;
(i) an operation by means of a laser beam.

Part B Multiple Surgical Procedures Expense Benefit

When Injury or Sickness requires multiple Surgical Procedures through the same incision, We will pay an amount not less than that for the most expensive procedure being performed. Multiple Surgical Procedures performed during the same operative session but through different incisions shall be reimbursed in an amount not less than the Covered Percentage of the Covered Charge of the most expensive Surgical Procedure then being performed[, and with regard to the less expensive Surgical Procedure in an amount equal to [50] percent of the Covered Percentage of the Covered Charge for these procedures].

[Part C Anesthesia Expense Benefit

If, in connection with such operation, the Insured Person requires the services of an anesthetist, We will pay the Expenses incurred; but We will not pay more than the Covered Percentage of the Covered Charges subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.]

[Part D Assistant Surgeon Expense Benefit

If, in connection with such operation, the Insured Person requires the services of an Assistant Surgeon, We will pay the Expense incurred; but We will not pay more than the Covered Percentage of the Covered Charges subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.]

[Part E Second Surgical Opinion Expense Benefit

We will also provide benefits to an Insured Person for a second opinion consultation by a board certified specialist on the need for non-emergency surgery which has been recommended by the Insured Person's Doctor. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Benefits will also be provided for any required x-rays and diagnostic tests done in connection with that consultation.

We will pay the Covered Charges incurred by the Insured Person as shown in the Plan of Insurance. [Any Deductible or Coinsurance is waived for Expenses incurred in connection with the Second Surgical Opinion.]

What We pay is shown in the Plan of Insurance.]

IN-HOSPITAL DOCTOR'S FEES AND MEDICAL EXPENSE BENEFIT

When, by reason of Injury or Sickness an Insured Person who is confined as a resident bed-patient in a Hospital, requires the services of a Doctor, who may or may not have performed the surgery on the Insured Person, We will pay the Covered Percentage of the Covered Charge incurred for such services, subject to the Deductible shown in the Plan of Insurance.

[The following medical services performed by a Doctor are covered on an inpatient basis:
[(a) one Doctor visit per day;]
[(b) constant care and treatment while an Insured Person is confined in an intensive care unit;]
[(c) care by two or more Doctors during one Hospital stay when the Insured Person's condition requires the skill of separate Doctors;]

[(d) consultation by another Doctor when requested by the Insured Person's Doctor. Coverage is limited to one consultation per admission. Staff consultations required by Hospital rules are not covered.]]

What We pay is shown in the Plan of Insurance.

OUTPATIENT EXPENSE BENEFIT

If, by reason of Injury or Sickness, an Insured Person incurs expenses in a Doctor's office, Hospital outpatient department, emergency room, clinical lab, radiological facility, or other similar facility licensed by the state, We will pay the Covered Percentage of the Covered Charges incurred as shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.

Outpatient Services

[Covered Charges for Outpatient Services include the following services:
(a) a Doctor's office while not Hospital Confined;
(b) chiropractic care up to the maximum shown in the Plan of Insurance;
(c) a Hospital outpatient department or emergency room;
(d) diagnostic x-ray and laboratory testing;
(e) blood and blood services, if provided and billed by a Hospital or other facility;
(f) physical and occupational therapy as shown in the Plan of Insurance;
(g) radiation therapy, intravenous chemotherapy, kidney dialysis, inhalation therapy;
(h) radiological lab or other similar facility licensed by the state;
(i) surgical dressings, splints, casts, and other devices used to correct fractures and dislocations;
(j) speech therapy by a licensed speech therapist to restore speech loss or correct speech impairment after corrective surgery, or following an Injury for Sickness other than a mental or learning disorder. Speech therapy must be in keeping with a Doctor's written order for type, frequency, and duration;
(k) shots and injections when received in the Doctor's office;
(l) immunizations [at the Student Health Center];
(m) acupuncture [up to the maximum shown in the Plan of Insurance.]
(n) allergy testing and/or treatment.]

If the Outpatient Services are in connection with surgery and the Doctor is the surgeon who performed or is to perform the surgery, no benefits are payable under this provision. All surgery charges are paid under the Surgical Expense Benefits provision.

[High Cost Procedures
High Cost Procedures, as used herein, means an outpatient procedure costing over {$200}..
Covered charges for High Cost Procedures include, but not limited to, charges for the following procedures and services.

(1) C.A.T. Scan;
(2) Magnetic resonance imaging; and
(3) Laser treatment.

The maximum benefit for High Cost Procedures is shown in the Plan of Insurance. If, by reason of similar benefit provision elsewhere contained, this Policy provides for reimbursement for the same charges, no benefits shall be payable under those provisions. These benefits are in place of all other benefits of this Policy.]

[**MATERNITY EXPENSE BENEFIT** *program may be offered on accident only or accident and sickness basis. Deleted if accident only, included if mandated for sickness*

We will pay benefits for an Insured Person's Covered Charges for maternity care, including Hospital, surgical and medical care.

We cover charges for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of inpatient care following an uncomplicated cesarean section for a mother and her newborn child in a health care facility, unless the attending Doctor, in consultation with the mother, makes a decision for an earlier discharge from the Hospital. The Doctor's approval to discharge must be made in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization.

For a mother and newborn child who remain in the Hospital for the minimum length of time stated above, We will pay for one home health care visit if prescribed by the attending Doctor.

For a mother and newborn child who have a shorter Hospital stay, We will pay for post-discharge care to the mother and her newborn. Post-discharge care will consist of two visits by a Doctor or a registered professional nurse with experience in maternal and child health nursing. The location and schedule of the visits will be determined by the Doctor. One visit must be in the Insured Person's home. Services may be provided in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or other nationally recognized medical organization.

Newborn Infant Care – Newborn infant care is covered when the infant is confined in the Hospital and has received continuous Hospital care from the moment of birth. [This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures.] [This benefit does not include circumcision.] This benefit also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children covered from birth.

Covered services may be provided by a certified nurse-midwife under qualified medical direction if he or she is affiliated with or practicing in conjunction with a licensed facility.

We cover such charges the same way We treat Covered Charges for any other Sickness. What We pay is shown in the Plan of Insurance.]

[**OPTIONAL MAMMOGRAPHIC EXAMINATION EXPENSE BENEFIT,** *program may be offered on accident only or accident and sickness basis. Deleted if accident only, included if mandated for sickness*

We will pay the Covered Percentage of the Covered Charges incurred for mammographic exams. The charges must be incurred while the Insured Person is insured for these benefits.

Benefits will be paid for mammographic exam charges incurred for the following:

(a) One baseline Mammogram for a woman 35 through 39 years of age;
(b) One Mammogram every 24 months for a woman forty through 49 years of age, inclusive, or more frequently upon recommendation of a Doctor;
(c) One Mammogram every12 months for a woman 50 years of age or older;
(d) A Mammogram for any woman, upon the recommendation of a Doctor, where such woman, her mother or her sister has a prior history of breast cancer.

We cover such charges the same way We treat Covered Charges for any other Sickness. What We pay is shown in the Plan of Insurance.

Definition: Mammogram means an X-ray examination of the breast using dedicated equipment, including X-ray tube, filter, compression device, screens, films and cassettes specifically for mammography that delivers an average radiation exposure of less than one rad mid-breast with two views for each breast. The term includes the professional interpretation of the film.]

[PELVIC, CERVICAL, PROSTATE AND COLORECTAL EXAM EXPENSE BENEFIT *program may be offered on accident only or accident and sickness basis. Deleted if accident only, included if mandated for sickness*

We will cover the Covered Percentage of Covered Charges for Expenses incurred for all of the following examinations:

(a) an annual pelvic examination and pap smear for any non-symptomatic female Insured Person; and
(b) an annual prostate examination and laboratory tests for any non-symptomatic male Insured Person; and

(c) an annual colorectal cancer examination and laboratory tests for any non-symptomatic Insured Person.

All examinations and laboratory tests must be performed in accordance with the current guidelines established by the American Cancer Society.

We cover such charges the same way We treat Covered Charges for any other Sickness. What We pay is shown in the Plan of Insurance.]

[ABORTION EXPENSE BENEFIT

If as a result of pregnancy an Insured Person has an Elective Abortion, We will pay the Covered Percentage of the Covered Charges incurred subject to the Deductible shown in the Plan of Insurance. Expenses for the Elective Abortion must be incurred while the Policy is in force as to the Insured Person.

Definition

Elective Abortion means an abortion for any reason other than a spontaneous abortion or to prevent the death of the female upon whom the abortion is performed

What We pay is shown in the Plan of Insurance.]

[ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) VACCINE EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for a vaccine for AIDS. Such vaccine must be:
approved for marketing by the federal Food and Drug Administration; and
recommended by the United States Public Health Service.

Provision of this benefit does not include coverage for any clinical trials relating to an AIDS vaccine or for any AIDS vaccine that has been approved by the federal Food and Drug Administration in the form of an investigational new drug application.

The policy exclusion for vaccines is amended to read as follows: Preventative medicines, serums or vaccines of any kind, excluding an AIDS vaccine as mandated by applicable law.

What We pay is shown in the Plan of Insurance.]

[AMBULANCE EXPENSE BENEFIT

When, by reason of Injury or Sickness, an Insured Person requires the use of a community or Hospital ambulance in a Medical Emergency, We will pay the Covered Percentage of the Covered Charges incurred as shown in the Plan of Insurance.

Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, scene of accident or Medical Emergency to a Hospital or between Hospitals.

Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area. Air transportation is covered when Medically Necessary because of a life threatening Injury or Sickness. Air ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for inpatient care.

What We pay is shown in the Plan of Insurance.]

[CONSULTANT EXPENSE BENEFIT

If by reason of Injury or Sickness, an Insured Person requires the services of a Consultant or Specialist when they are deemed necessary and ordered by an attending Doctor for the purpose of confirming or determining a diagnosis, We will pay the Covered Percentage of the Covered Charges incurred.

What We pay is shown in the Plan of Insurance.]

[DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

If, by reason of Injury or Sickness, an Insured Person requires the use of Durable Medical Equipment, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for such Durable Medical Equipment, subject to the Deductible shown in the Plan of Insurance. We pay the Covered Percentage of the Covered Charges incurred by the Insured Person for the purchase of such Durable Medical Equipment when the purchase price is expected to be less costly than rental. If Durable Medical Equipment is purchased it is our property and is to be returned to Us, at Our expense, upon completion of the Insured Person's need, if so requested by Us.

We do not pay for the replacement of Durable Medical Equipment.

What We pay is shown in the Plan of Insurance.

Definition

Durable Medical Equipment means medical equipment that: 1) is prescribed by the Doctor who documents the necessity for the item including the expected duration of its use; 2) can withstand long term repeated use without replacement; 3) is not useful in the absence of an Injury or Sickness; and 4) can be used in the home without medical supervision.]

[HOME HEALTH CARE EXPENSE BENEFIT *included if mandated by state*

We will cover charges for Home Health Care services furnished to an Insured Person. Such benefits must be provided by a licensed Home Health Agency.

We will pay for Covered Charges up to a maximum of {100 visits} in any calendar year or in any continuous period of 12 months. Covered Charges are subject to {80%} of the Reasonable and Customary Expense. Except for a home health aide, each visit by a representative of a Home Health Agency shall be considered as one home health visit. A visit of four (4) hours or less by a home health aide, shall be considered as one home health visit.

Charges for such services are not subject to the Deductible.

What We pay in shown in the Plan of Insurance.

Definitions

Home Health Care means the continued care and treatment of an Insured Person who is under the direct care and supervision of a Doctor but only if: (a) continued hospitalization would have been required if Home Health Care were not provided; (b) the home health treatment plan is established and approved by a Doctor within 14 days after an inpatient Hospital Confinement has ended and such treatment plan is for the same related condition for which the Insured Person was hospitalized; and (c) Home Health Care commences within 14 days after the Hospital Confinement has ended.

Home Health Services Consist of, but shall not be limited to, the following: (a) part-time or intermittent skilled nursing services provided by a registered nurse or licensed vocational nurse; (b) part-time or intermittent home health aide services which provide supportive services in the home under the supervision of a registered nurse or a physical, speech or occupational therapist; (c) physical, occupational or speech therapy; and (d) medical supplies, drugs and medicines prescribed by a Doctor and related pharmaceutical services, and laboratory services to the extent such charges or costs would have been covered under the Policy if the Insured Person had remained in the Hospital.

Home Health Agency means a public or private agency or organization licensed by the State Department of Health Services in accordance with the provisions of the Health and Safety Code.]

[LARYNGECTOMY EXPENSE BENEFIT

We pay benefits for charges for Prosthetic Devices to restore a method of speaking for the Insured Person incident to a Laryngectomy.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

Definitions:
Laryngectomy means the removal of the larynx for Medically Necessary reasons, as determined by a licensed Doctor and surgeon.

Prosthetic Devices means and includes the provision of initial and subsequent Prosthetic Devices, including installation accessories, pursuant to an order of the patient's Doctor and surgeon. Prosthetic Devices does not include electronic voice producing machines.]

[LICENSED NURSE EXPENSE BENEFIT

If by reason of Injury or Sickness, an Insured Person requires the service of a licensed nurse or licensed practical nurse during a Hospital Confinement, We will pay the Covered Percentage of the Covered Charges incurred subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.]

[OPTIONAL HOSPICE EXPENSE BENEFIT

If an Insured Person is Terminally Ill and requires a coordinated plan of home and inpatient care, We will cover charges for hospice services furnished to the Insured Person on the same basis as any other Sickness. The services must be under active management through a licensed hospice and approved by Us.

Covered Services will include:
(a) part-time intermittent home nursing care by or under the direction of a graduate Registered Nurse;
(b) medical supplies, equipment, and medication required to maintain the comfort and manage the pain of the Terminally Ill Insured Person.
(c) counseling, including dietary counseling, for the Terminally Ill Insured Person;
(d) Family Counseling for the immediate family and the family caregiver before the death of the Terminally Ill Insured Person;
(e) Bereavement Counseling for the immediate family or family caregiver of the Insured for at least the 6 month period following the Insured Person’s death or 15 visits, whichever occurs first.

What We pay is shown in the Plan of Insurance.

Definitions

Terminally Ill means a medical prognosis given by a Doctor that the Insured Person’s life expectancy is six months or less.

Bereavement Counseling means counseling provided to the immediate family or family caregiver of the insured after the Insured Person’s death to help the immediate family or family caregiver cope with the death of the Insured Person.

Family Counseling means counseling given to the immediate family or family caregiver of the Terminally Ill Insured Person for the purpose of learning to care for the Insured Person and to adjust to the death of the Insured Person.]

[PRE-ADMISSION TESTS EXPENSE BENEFIT *included if mandated by state*

Notwithstanding any provision in the Policy to the contrary, We will pay benefits for Covered Charges made by a Hospital for use of its outpatient facilities for tests ordered by a Doctor. The tests must be performed as a planned preliminary to the Insured Person's admission as an inpatient for surgery in that same Hospital. However: (a) the test must be necessary for, and consistent with, the diagnosis and treatment of the condition for which surgery is to be performed; (b) reservations for a Hospital bed and for an operating room must be made prior to the date the tests are done; (c) the surgery actually takes place within [seven] days of pre-surgical tests; and (d) the Insured Person is physically present at the Hospital for the tests.

No benefit shall be payable under this provision in excess of either: (1) the benefits that would have been provided under this Policy had the Insured Person received those tests while confined in the Hospital as a resident bed-patient; or (2) the Miscellaneous Hospital Expense Maximum shown in the Plan of Insurance for the Miscellaneous Hospital Expense Benefit.

If, by reason of similar benefit provisions elsewhere contained, the Policy provides for reimbursement for the same charges, no benefits shall be payable under these provisions, except to the extent by which the amount of benefit produced under those provisions for a given charge exceeds the amount of benefits produced for that same charge under this provision.

This provision shall apply with respect to the Insured Person only to the extent that the Insured Person is insured under this Policy for Hospital Expense Benefits.

What We pay is shown in the Plan of Insurance.]

[PRESCRIPTION DRUG EXPENSE BENEFIT

If by reason of Injury or Sickness, an Insured Person requires drugs, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for such drugs and the Medically Necessary services associated with the administration of such drugs, subject to the Copayment shown in the Plan of Insurance.

The drugs must be prescribed by a Doctor. We only cover drugs which are approved for the treatment of the Insured Person's Injury or Sickness by the Food and Drug Administration. We will also cover a drug prescribed for a treatment for which it has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established reference compendia:

(1) the American Medical Association Drug Evaluations;
(2) the American Hospital Formulary Service Drug Information;
(3) the United States Pharmacopoeia Drug Information; or
(4) it is recommended by a clinical study or review article in two major peer-reviewed professional journals that present data supporting the use or uses to be generally safe and effective.

Also covered are prescription drugs or devices approved by the federal Food and Drug Administration for use as a contraceptive.

However, Covered Charges do not include experimental or investigational drugs or any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed or for any drug or device intended to induce an abortion.

What We pay is shown in the Plan of Insurance.]

[PROSTHETICS APPLIANCE AND ORTHOTIC DEVICE EXPENSE BENEFIT

If, by reason of Injury or Sickness, an Insured Person requires the use of a Prosthetic Appliance or Orthotic Device, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for the purchase, initial fitting, and needed adjustment of such appliances or devices, as shown in the Plan of Insurance.

We do not pay for the replacement of Prosthetic Appliances or Orthotic Devices.

What We pay is shown in the Plan of Insurance.

Definitions

Prosthetic Appliance means a device, or artificial appliance, that: (1) maintains or replaces the body part of an Insured Person whose covered Injury or Sickness has required the removal of that body part; and (2) is prescribed by the Insured Person's Doctor who documents the necessity for the item.

Orthotic Device means a mechanical device, such as braces (but not dental) or shoes, that: (1) is directly related to the treatment of an Injury or Sickness; and (2) is prescribed by the Insured Person's Doctor who documents the necessity for the item.]

[SICKNESS DENTAL EXPENSE BENEFIT

If, by reason of Sickness, an Insured Person requires treatment for impacted wisdom teeth or dental abscesses, We will pay the Covered Percentage of the Covered Charges incurred subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.]

[SKILLED NURSING FACILITY EXPENSE BENEFIT

If an Insured Person requires continuing treatment in a Skilled Nursing Facility following hospitalization, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for treatment in such Skilled Nursing Facility.

The services must be Medically Necessary as a continuation of treatment for the condition for which the Insured Person was previously hospitalized. The Insured Person must be admitted to the Skilled Nursing Facility **[**within 24 hours**]** following a Medically Necessary Hospital stay.

We cover such charges the same way We treat Covered Charges for any Hospital Confinement.

What We pay is shown in the Plan of Insurance.

Definition:
Skilled Nursing Facility means a facility that is primarily engaged in providing inpatient skilled nursing care and related services to patients requiring convalescent and rehabilitative care. The facility must:

(a) be directed by a duly licensed Doctor;
(b) provide continuous 24 hour a day nursing service by or under the supervision of a registered graduate professional nurse (RN);
(c) maintain a daily medical record of each patient;
(d) be operated pursuant to law and appropriately licensed or certified;
(e) be certified by the Medicare program.

Such facility must not include any home, facility or part thereof, used primarily:
(a) for rest or treatment of tuberculosis;
(b) for the aged, or for the care of drug addiction;
(c) for the care and treatment of mental diseases or disorders, or custodial or educational care.]

[STUDENT HEALTH CENTER REFERRAL

In order to obtain the maximum benefit available when medical treatment is needed, the Insured Student must go to the Student Health Center (SHC) first where treatment will be administered or a referral issued. **[**Such charges are subject to the Deductible.] Expenses incurred for medical treatment rendered outside of the Student Health Center for which no prior approval or referral is obtained [are excluded from coverage] [will be paid at {80%} of the benefits otherwise payable under the Plan of Insurance]. A referral issued by the SHC must accompany the claim when submitted.

A SHC referral for outside care is not necessary only under the following conditions:
(1) [Medical Emergency; (The student [and Dependent] must return to SHC for necessary follow-up care.)]
(2) [When the Student Health Center (SHC) is closed;]
(3) [When service is rendered at another facility during break or vacation periods;]
(4) [Medical care received when the student is more than {50} miles from campus;]
(5) [Medical care obtained when a student is no longer able to use the SHC due to a change in students status;]
(6) [Maternity; or]
(7) [Psychotherapy.]

[Dependents are not eligible to use the SHC; and therefore, are exempt from the above limitations and requirements.]]

[EMERGENCY MEDICAL EVACUATION EXPENSE BENEFIT

This benefit applies only to [Domestic Students [while Studying Abroad],] [International Students,] [and their Dependents]. This benefit will pay benefits for the Covered Percentage of the Covered Expenses incurred, if any Injury [or Sickness] results in the Emergency Medical Evacuation of the Insured Person.

What We pay is shown in the Plan of Insurance.

Definitions:

Emergency Medical Evacuation means:
(a) the Insured Person's medical condition warrants immediate Transportation from the place where the Insured Person is injured or ill to the nearest Hospital [or home residence] where appropriate medical treatment can be obtained; or
(b) for [Domestic Students while Studying Abroad,] [International Students,] [and their Dependents] after being treated at a local Hospital; the Insured Person's medical condition warrants Transportation to his/her Home Country to obtain further medical treatment to recover.

Covered Expenses are Expenses up to the maximum stated in the Plan of Insurance for: (a) Transportation, (b) medical services, and (c) medical supplies necessarily incurred in connection with Emergency Medical Evacuation of the Insured Person. All Transportation arrangements made for evacuating the Insured Person must be: (a) by the most direct and economical conveyance; and (b) approved in advance by the Company.

Home Country means the country from which the Insured Person holds a passport. Where the Insured Person holds more than one passport, the Home Country will be the country that the Insured Person has declared with the Company.

Transportation means any land, water or air conveyance required to transport the Insured Person during an Emergency Medical Evacuation. Expenses for special transportation must be: (a) recommended by the attending Doctor; or (b) required by the standard regulations of the conveyance transporting the Insured Person. Special transportation includes, but is not limited to: air ambulance, land ambulance, and private motor vehicle. Expenses for medical supplies and services must be recommended by the attending Doctor.]

[REPATRIATION OF BODY REMAINS EXPENSE BENEFIT
This benefit applies only to [Domestic Students [while Studying Abroad],] [International Students,] [and their Dependents]. In the event of the death of an Insured Person, We will pay the actual charges for the Covered Expenses for the preparation and transportation of the Insured Person's remains to his or her Home Country [or home residence]. This will be done in accord with all legal requirements in effect at the time the body remains are to be returned to his or her Home Country. The death must occur while the person is insured for this benefit.

What We pay is shown in the Plan of Insurance.

Definitions

Covered Expenses include, but are not limited to, Expenses for embalming, cremation, coffins, and transportation.

Home Country means the country from which the Insured Person holds a passport. Where the Insured Person holds more than one passport, the Home Country will be the country that the Insured Person has declared with the Company.]

[CHILD IMMUNIZATION EXPENSE BENEFIT *included if dependent children covered and mandated for accident and sickness*

We will pay the Covered Charges incurred for immunizations of a covered Dependent child from birth to five (5) years of age. We cover such charges the same way We treat Covered Charges for any other Sickness, except Covered Charges for this benefit are not subject to any Deductible or Copayment provisions.

What We pay is shown in the Plan of Insurance.]

[DENTAL ANESTHESIA AND HOSPITALIZATION EXPENSE BENEFIT *included if mandated*

We will pay the Covered Percentage of the Covered Charges incurred for the administration of general anesthesia and Hospital and licensed ambulatory surgical facility charges for dental care provided to an Insured Person in such Hospital or ambulatory surgical facility if:

(a) The Doctor treating the Insured Person certifies that because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedure; and

(b) The patient:

(1) is a child under the age of seven who is determined by 2 dentists licensed under Arkansas law to require without delay necessary dental treatment in a hospital or ambulatory surgical center for significantly complex dental condition; or

(2) a person with a diagnoses serious mental or physical dondition; or

(3) a person with a significant behavioral problem as determined by the covered person's physician as licensed under the Arkansas Medical Practice Act.

Treatment may be provided by a dentist in either a Hospital or licensed ambulatory surgical facility.

We cover such charges the same way We treat Covered Charges for any other Injury or Sickness.

What We pay is shown in the Plan of Insurance.]

[ENTERAL FORMULA EXPENSE BENEFIT *included if dependent children covered and mandated for accident and sickness*

We will pay the Covered Percentage of the Covered Charges incurred for a formula or formulas recommended by a Doctor for the treatment of an Insured Person who is less than six (6) years of age with phenylketonuria or any inherited disease of amino or organic acids.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.]

[**BREAST RECONSTRUCTION AFTER MASTECTOMY EXPENSE BENEFIT** *included if mandated for accident and sickness*

If an Insured Person who is receiving benefits under the Policy in connection with a mastectomy elects breast reconstruction in connection with such mastectomy, Covered Charges include those incurred for:

(a) reconstruction of the breast on which the Mastectomy has been performed;
(b) surgery and reconstruction of the nondiseased breast To Restore and Achieve Symmetry;
(c) Prosthetic Devices and treatment of physical complications for all stages of a Mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes); and
(d) hospitalization, for a length of stay as determined by the attending Doctor and surgeon in consultation with the Insured Person, and consistent with sound clinical principles and processes

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

Definitions

Coverage for Prosthetic Devices or Reconstructive Surgery means any initial and subsequent reconstructive surgeries or Prosthetic Devices, and follow-up care deemed necessary by the attending Doctor and surgeon.

Prosthetic Devices means the provision of initial and subsequent devices pursuant to an order of the patient's Doctor and surgeon.

Mastectomy means the removal of all or part of the breast for Medically Necessary reasons, as determined by a licensed Doctor and surgeon.

To Restore and Achieve Symmetry means that, in addition to Coverage for Prosthetic Devices or Reconstructive Surgery for the diseased breast on which the Mastectomy was performed, Prosthetic Devices and reconstructive surgery for the healthy breast is also covered if, in the opinion of the attending Doctor and surgeon, this surgery is necessary to achieve normal symmetrical appearance.]

[NEWBORN HEARING SCREENING EXPENSE BENEFIT *included if dependent children covered and mandated for accident and sickness*

We will pay the Covered Percentage of the Covered Charges incurred for hearing screening, necessary rescreening, audiological assessment and follow-up and initial amplification for a newborn Dependent.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.]

[OSTEOPOROSIS EXPENSE BENEFIT *included if mandated for accident and sickness*

We will pay the Covered Percentage of the Covered Charges incurred for diagnosis, treatment and appropriate management of osteoporosis for Insured Persons with a condition or medical history for which bone mass measurement is medically indicated. In determining whether testing or treatment is medically appropriate the Doctor shall give due consideration to peer reviewed medical literature.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.]

[**OPTIONAL CHILD HEALTH SUPERVISION SERVICES EXPENSE BENEFIT** *included if dependent children covered and mandated for accident and sickness*

We will pay the Covered Percentage of the Covered Charges incurred for Child Health Supervision Services for a covered Dependent child from the moment of birth to 12 years of age. Such services will be provided at approximately the following

age intervals: birth; two (2) months; four (4) months; six (6) months; nine (9) months; 12 months; 18 months; two (2) years; three (3) years; four (4) years; five (5) years; six (6) years; eight (8) years; ten (10) years and 12 years.

Benefits are limited to one visit payable to one provider for all of the services at each visit.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

Definition:

Child Health Supervision Services means the periodic review of a covered Dependent child's physical and emotional status by a Doctor or pursuant to a Doctor's supervision. A review shall include: a) a history; b) physical examination; c) developmental assessment; d) anticipatory guidance; e) appropriate immunizations; and f) laboratory tests, in keeping with prevailing medical standards.]

BREAST CANCER EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to a nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants.

We cover such charges the same way We treat Covered Charges for any other Sickness, except that the Lifetime Maximum Benefit payable for each Insured Person is limited to $100,000.

What We pay is shown in the Plan of Insurance.

LOSS/IMPAIRMENT OF SPEECH/HEARING EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for the Medically Necessary care and treatment of the Loss or Impairment of Speech or Hearing.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

Definition

Loss or Impairment of Speech or Hearing means those communicative disorders generally treated by a speech pathologist, audiologist or speech language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA) or both and which fall within the scope of his or her license or certification.

DIABETES EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for Doctor prescribed Medically Necessary equipment, supplies and self-management training used in the management and treatment of Diabetes.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

Definition: Diabetes means an Insured Person with gestational, type I or type II diabetes.

LEAD POISONING TESTING EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for the testing of insured pregnant women for lead poisoning and for all testing for lead poisoning authorized by Missouri law or regulation.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

[OPTIONAL CHEMICAL DEPENDENCY AND MENTAL ILLNESS EXPENSE BENEFIT

A. Covered Charges for Treatment of Chemical Dependency

We will pay the Covered Percentage of the Covered Charges incurred for the Medically Necessary care and treatment of Chemical Dependency on the same basis as for any other Sickness, subject to the following limits:

1. Outpatient treatment through a Nonresidential Treatment Program or through partial- or full-Day Program Services, up to 26 days per Policy Year.
2. Residential Treatment Program, up to 21 days per Policy Year.
3. Medical and Social Setting Detoxification, up to six (6) days per Policy Year.
4. Lifetime limit of 10 Episodes of treatment per Insured Person, except that this frequency maximum will not apply to Medical Detoxification in a life-threatening situation as determined by the treating Doctor and subsequently documented within 48 hours of treatment to our reasonable satisfaction.

B. Covered Charges for Treatment of Recognized Mental Illness

We will pay the Covered Percentage of the Covered Charges incurred for the Medically Necessary care and treatment of Recognized Mental Illness (excluding Chemical Dependency) to the same extent as any other covered Sickness for the following services:

1. Outpatient treatment, including treatment through partial or full-Day Program Services, for mental health services rendered by a licensed professional, {20-60} visits per Policy Year.
2. Residential treatment programs for therapeutic care when prescribed by a licensed professional and rendered in a psychiatric Residential Treatment Center.
3. Inpatient Hospital treatment,{30 – 90} days per Policy Year.

[We may administer the above Covered Charges through a Managed Care Program established by Us. Covered services may be delivered through a system of contractual arrangements with one or more providers, Hospitals, Nonresidential or Residential Programs or other mental health service delivery entities certified by the Missouri Department of Mental Health or accredited by a nationally recognized organization or licensed by the state of Missouri.**]**

C. Covered Charges for Other Mental Health Benefits

We will pay the Covered Percentage of the Covered Charges incurred for two sessions per Policy Year with a licensed psychiatrist, licensed psychologist, licensed professional counselor or licensed clinical social worker who is acting within the scope of such license on the same basis as for any other Sickness, subject to the following:

1. Care must be for the purpose of diagnosis or assessment, but not dependent upon findings;
2. Services are not subject to prior approval, pre-authorization or pre-certification and are reimbursable as long as the provisions of this benefit are satisfied;
3. Benefits are subject to the same Coinsurance, Copayment and Deductible factors of the Policy that apply to regular office visits for physical Sickness.

What We pay is shown in the Plan of Insurance.

Definitions:

Chemical Dependency means the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

Community Mental Health Center means a legal entity certified by the Missouri Department of Mental Health or accredited by a nationally recognized organization, through which a comprehensive array of mental health services are provided to individuals.

Day Program Services means a structured, intensive day or evening treatment or partial hospitalization program, certified by the Missouri Department of Mental Health or accredited by a nationally recognized organization.

Episode means a distinct course of Chemical Dependency treatment separated by at least 30 days without treatment.

Licensed Professional means a licensed Doctor specializing in the treatment of mental illness, a licensed psychologist, a licensed clinical social worker or a licensed professional counselor.

Managed Care means the determination of availability of coverage through the use of clinical standards to determine the medical necessity of an admission or treatment, and the level and type of treatment, and appropriate setting for treatment, with required authorization on a prospective, concurrent or retrospective basis, some involving case management.

Medical Detoxification means Hospital inpatient or residential medical care to ameliorate acute medical conditions associated with Chemical Dependency.

Nonresidential Treatment Program means a program certified by the Missouri Department of Mental Health involving structured, intensive treatment in a nonresidential setting.

Recognized Mental Illness means the following disorders contained in the International Classification of Diseases (ICD-9-CM):
(a) Schizophrenic disorders and paranoid states (295 and 297, except 297.3);
(b) Major depression, bipolar disorder, and other affective psychoses (296);
(c) Obsessive compulsive disorder, post-traumatic stress disorder and other major anxiety disorders (300.0, 300.21, 300.22, 300.23, 300.3 and 309.81);
(d) Early childhood psychoses, and other disorders first diagnosed in childhood or adolescence (299.8, 312.8, 313.81 and 314);
(e) Alcohol and drug abuse (291, 292, 303, 304, and 305, except 305.1); and
(f) Anorexia nervosa, bulimia and other severe eating disorders (307.1, 307.51, 307.52 and 307.53);
(g) Senile organic psychotic conditions (290).

Residential Treatment Program means a program certified by the Missouri Department of Mental Health involving residential care and structured, intensive treatment.

Social Setting Detoxification means a program in a supportive nonhospital setting designed to achieve detoxification, without the use of drugs or other medical intervention to establish a plan of treatment and provide for medical referral when necessary.]

[The Policyholder will choose either the Chemical Dependency And Mental Illness Expense Benefit or the Alcoholism Treatment Expense Benefit.]

[OPTIONAL ALCOHOLISM TREATMENT EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for the treatment of alcoholism in a Hospital or in a residential or nonresidential facility certified by the Arkansas Department of Mental Health the same as any other Sickness, subject to a Policy Year maximum of 30 days per confinement.

What We pay is shown in the Plan of Insurance.**]**

[RECONSTRUCTIVE SURGERY EXPENSE BENEFIT

We cover charges for Reconstructive Surgery that is necessary to improve function or create a normal appearance.

Exception:
Cosmetic Surgery is performed to alter or reshape normal structures of the body in order to improve the patient's appearance and is therefore **not** a Covered Charge.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

Definitions:

Reconstructive Surgery means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:
(a) to improve function; and
(b) to create a normal appearance, to the extent possible.]

[SEVERE MENTAL ILLNESS (ADULTS AND CHILDREN)
AND SERIOUS EMOTIONAL DISTURBANCES OF CHILDREN EXPENSE BENEFIT *included if mandated for accident and sickness*

If an Insured Person requires treatment for Severe Mental Illness, We will pay for such treatment of a person of any age and for Serious Emotional Disturbances of a Child under the same terms and conditions applied to other medical conditions.

The benefits shall include to following:
(a) outpatient services;
(b) inpatient Hospital services;
(c) partial Hospital services; and
(d) prescription drugs, if the Policy includes prescription drug coverage.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

Definitions

Severe Mental Illness shall include: Schizophrenia; Schizoaffective disorder; Bipolar disorder (manic-depressive illness); Major depressive disorders; Panic disorder; Obsessive-compulsive disorder; Pervasive developmental disorder or autism; Anorexia nervosa; and Bulimia nervosa.

Serious Emotional Disturbances of a Child means a child who: (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms; and (2) meets the criteria of applicable state law.]

[SIGMOIDOSCOPIC EXPENSE BENEFIT

If an Insured Person requires a Sigmoidoscopic exam, We will pay the Covered Percentage of the Covered Charges incurred for Sigmoidoscopic exams.

Benefits will be paid for Sigmoidoscopic exam charges incurred for the following:

(a) One baseline Sigmoidoscopy at age fifty through fifty-five; and
(b) One Sigmoidoscopy every three to five years thereafter. If preferred, an annual fecal occult blood test may be alternatively used.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

Definition:

Sigmoidoscopy means inspection through an endoscope of the interior of the sigmoid colon for the purposes of identifying liason(s) including polyps, cancer, ulceratrions, or diverticulum.]

[OPTIONAL TEMPOROMANDIBULAR JOINT/CRANIOMANDIBULAR DISORDER EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for surgical and non-surgical treatment of a temporomandibular joint and/or craniomandibular disorder.

We cover such charges the same way We treat Covered Charges for any other Sickness. But, We will not pay more than $3,000 in an Insured Person's lifetime.

What We pay is shown in the Plan of Insurance.]

[TREATMENT OF MORBID OBESITY EXPENSE BENEFIT

If an Insured Person requires treatment for Morbid Obesity, We will pay the Covered Percentage of the Covered Charges incurred for medically diagnosed morbid obesity in accordance with medically established and approved treatment protocol.

We cover such charges the same was We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.]

[CLINICAL TRIALS FOR PREVENTION, EARLY DETECTION AND TREATMENT OF CANCER EXPENSE BENEFIT
included if mandated for accident and sickness

We will pay the Covered Percentage of the Covered Charges incurred for Routine Patient Care Costs as the result of phase II, III, or IV of a clinical trial that is approved by an Entity and is undertaken for the purposes of the prevention, early detection, or treatment of cancer.

In the case of treatment under a clinical trial, the treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. There must be equal to or superior, noninvestigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the noninvestigational alternatives.

Coverage shall include coverage for routine patient care costs incurred for drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, including coverage for reasonable and medically necessary services needed to administer the drug or use the device under evaluation in the clinical trial.

Coverage for routine patient care costs shall apply to phase III or IV of clinical trials that are approved or funded by an Entity.

Coverage for routine patient care costs shall apply to phase II of clinical trials if:

(1) Phase II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and

(2) The person covered under this section is enrolled in the clinical trial. This section shall not apply to persons who are only following the protocol of phase II of a clinical trial, but not actually enrolled.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

Definitions

Entity means any of the following:

(1) One of the National Institutes of Health (NIH);

(2) An NIH cooperative group or center as defined in subsection 7 of this section;

(3) The FDA in the form of an investigational new drug application;

(4) The federal Departments of Veterans' Affairs or Defense;

(5) An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects (45 CFR 46); or

(6) A qualified research entity that meets the criteria for NIH Center support grant eligibility.

Cooperative group means a formal network of facilities that collaborate on research projects and have an established NIH-approved Peer Review Program operating within the group, including the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;

Multiple project assurance contract means a contract between an institution and the federal Department of Health and Human Services (DHHS) that defines the relationship of the institution to the DHHS and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects;

Routine patient care costs mean coverage for reasonable and medically necessary services needed to administer the drug or device under evaluation in the clinical trial. Routine patient care costs include all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

(a) The investigational item or service itself;

(b) Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and

(c) Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.**]**

[ANNUAL ROUTINE EXAM EXPENSE BENEFIT

We will pay the Covered Charges for an annual routine physical exam or gynecological exam up to a maximum of $150.00 per policy year.]

[BREAST IMPLANT REMOVAL EXPENSE BENEFIT

We cover charges for the Medically Necessary removal of breast implants, including implants that involved cosmetic surgery performed for reasons of reconstruction, that were done as a result of Injury or Sickness. However, removal of breast implants is not covered if the surgery was done solely for cosmetic reasons.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.]

[INFERTILITY EXPENSE BENEFIT *included if mandated for accident and sickness*

We cover charges for the diagnosis and treatment of infertility including, but not limited to: in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and low tubal ovum transfer. Cryopreservation, the procedure whereby embryos are frozen for late implantation, shall be included as an in vitro fertilization procedure.

Benefits, for the above procedures will only be paid regardless of the Experimental or Investigational nature of such procedures. We cover such charges the same way We treat Covered Charges for any other Sickness subject to the following conditions:

(1) The patient is the Insured Student or the spouse of the Insured Student and a covered dependent under the Policy, and

(2) The patient's oocytes are fertilized with the sperm if the patient's spouse, and

(3) (a) The patient and the patient's spouse have a history of unexplained infertility of at least 2 years' duration; or (b) The infertility is associated with one or more of the following medical conditions: endometriosis;, exposure to Diethylstilbestrol, commonly known as DES; blockage of or a removal of one or both fallopian tubes (lateral or bilateralsalpingectomy) not a result of voluntary sterilization, or abnormal male factors contributing to the infertility, and

(4) The in vitro fertilization procedures are performed at a medical facility, licensed or certified by the Arkansas Department of Health, those performed at a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization, and

(5) The patient has been unable to obtain successful pregnancy through less costly applicable infertility treatment for which coverage is available under the policy.

What We pay is shown in the Plan of Insurance.]

[MASTECTOMY EXPENSE BENEFIT *included if mandated for accident and sickness*

We cover charges for prosthetic devices; and reconstructive surgery incident to a mastectomy.

Coverage for prosthetic devices and reconstructive surgery will be subject to the Deductible and Covered Percentage provisions shown in the Plan of Insurance and is limited to two years after performance of a covered mastectomy which had revealed no evidence of malignancy.

What We pay is shown in the Plan of Insurance.]

Definition

Mastectomy means the removal of all or part of the breast for reasons that are determined by a licensed Doctor to be Medically Necessary.]

[POST-MASTECTOMY EXPENSE BENEFIT *included if mandated for accident and sickness*

We cover charges for: (a) inpatient coverage following a mastectomy for a length of time determined by the attending Doctor to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence; and (b) a post-discharge Doctor office visit or in-home nurse visit to verify the condition of the patient in the first 48 hours after discharge.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.]

[PEDIATRIC PREVENTIVE CARE EXPENSE BENEFIT *included if dependent children covered and mandated for accident and sickness*

We cover charges for preventive services rendered to a child enrolled as a dependent including physical examinations, immunizations, history measurements, sensory screening, neuropsychiatric evaluation and development screening and assessment at the following intervals: (a) six times during the first year after birth; (b) up to a maximum of three times during the next year; and (c) annually until age 6.

Such charges will not be subject to a Deductible, if any.

What We pay is shown in the Plan of Insurance.]

[PROSTATE-SPECIFIC ANTIGEN EXPENSE BENEFIT *included if mandated for accident and sickness*

If an Insured Person requires a Prostate-Specific Antigen test, We will pay the Covered Percentage of the Covered Charges incurred for one annual digital rectal examination and a Prostate-Specific Antigen Test, for male insureds upon the recommendation of a Doctor licensed to practice medicine in all its branches for:

(a) Asymptomatic men age 50 and over;
(b) African-American men age 40 and over; and
(c) Men age 40 and over with a family history of prostate cancer.

What We pay is shown in the Plan of Insurance.]

[DAY SURGERY MISCELLANEOUS EXPENSE BENEFIT

We cover charges for day surgery miscellaneous expenses related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies.

Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.

What We pay is shown in the Plan of Insurance.]

TELEMEDICINE MEDICAL SERVICE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred as shown in the Plan of Insurance for Telemedicine.

Prior to the delivery of health care via telemedicine, a Doctor who has ultimate authority over the care or primary diagnosis of the patient shall obtain verbal and written informed consent from the patient or the patient's legal representative. The informed consent procedure shall ensure that at least all of the following information is given to the patient or the patient's legal representative verbally and in writing:

(1) The patient or the patient's legal representative retains the option to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which the patient or the patient's legal representative would otherwise be entitled.

(2) A description of the potential risks, consequences, and benefits of telemedicine.

(3) All existing confidentiality protections apply.

(4) All existing laws regarding patient access to medical information and copies of medical records apply.

(5) Dissemination of any patient identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without the consent of the patient.

A patient or the patient's legal representative shall sign a written statement prior to the delivery of health care via telemedicine, indicating that the patient or the patient's legal representative understands the written information provided and that this information has been discussed with the Doctor.

The written consent statement signed by the patient or the patient's legal representative shall become part of the patient's medical record.

Definition

Telemedicine
This term means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medicaldata, and education using interactive audio, video, or data communications. Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient constitutes “telemedicine”.

Interactive
This term means an audio, video, or data communication involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information.

[**PHENYLKETONURIA EXPENSE BENEFIT**

We will cover charges for amino acid modified preparations, low protein modified food products, and any other special dietary products and formulas prescribed under the direction of a physician for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism, that are part of a diet prescribed by a licensed Doctor and managed by a health care professional in consultation with a Doctor who specializes in the treatment of metabolic disease. Such coverage is provided if the diet is deemed Medically Necessary to avoid the development of serious physical or mental disabilities or to promote normal development for function as a consequence of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism

[We cover such charges the same way We treat Covered Charges for any other Sickness.]

What We pay is shown in the Plan of Insurance.

Definitions

Formula
This term means an enteral product or enteral products for use at home that are prescribed by a Doctor or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments, as Medically Necessary for the treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism.

Coverage is not required except to the extent that the cost of necessary Formulas and Special Food Products exceeds the cost of a normal diet.

Special Food Products
This term means a food product that is both of the following:

(a) prescribed by a Doctor or nurse practitioner for the treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism, and is consistent with the recommendations and best practices of qualified health professionals with expertise and experience in the treatment and care of such conditions or disorders. It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving; and
(b) used in place of normal food products, such as grocery store foods, used by the general population.]

[PREVENTIVE CARE FOR DEPENDENT CHILDREN EXPENSE BENEFIT

We cover charges for one visit for children's preventive health care services for a covered Dependent at each of the following age intervals:

(A) Birth;
(B) 2 weeks;
(C) 2 months;
(D) 4 months;
(E) 6 months;
(F) 9 months;
(G) Twelve months;
(H) Fifteen months;
(I) Eighteen months;
(J) 2 years;
(K) 3 years;
(L) 4 years;
(M) 5 years;
(N) 6 years;
(O) 8 years;
(P) 10 years;
(Q) Twelve years;
(R) Fourteen years;
(S) Sixteen years; and
(T) Eighteen years.

Benefits are limited to one Doctor (provider) per visit for all services rendered.

Benefits for recommended immunization services are exempt from any copayment, coinsurance, deductible, or dollar limit provisions in the policy. All other children's preventive health care services will be paid as any other Sickness.

What We pay is shown in the Plan of Insurance.**]**

Definitions:

Children's preventive health care services means physician-delivered or physician-supervised services for eligible dependents from birth through eighteen (18) years of age, with periodic preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards.

Periodic preventive care visits means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.]

GENERAL EXCLUSIONS AND LIMITATIONS

The Policy does not cover nor provide benefits for:

1. [Services normally provided without charge by the Policyholder's student health service center, infirmary, or Hospital, or by Health Care Providers employed by the Policyholder;]

2. [Preventative medicines, serums, immunizations, or vaccines, except as specifically provided;]

3. [Speech therapy treatment, except as specifically provided;]

4. [Private duty nursing or skilled nursing services, except as specifically provided;]

5. [Home health care services, except as specifically provided;]

6. [Care and/or treatment in skilled nursing facility, except as specifically provided;]

7. [Organ transplants, except as specifically provided;]

8. [Hospice services, except as specifically provided;]

9. [Pre-existing Conditions as defined in this Policy.]

10. [Nonprescription drugs or medicines;]

11. [Injury sustained or Sickness contracted while in service of the Armed Forces of any country, except as specifically provided. Upon the Insured Person entering the Armed Forces of any country, We will refund the unearned pro-rata premium to such Insured Person;]

12. [Illness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with [intercollegiate sports], [intercollegiate club sports], [and professional sports];]

13. [Injury resulting from motor vehicle accident to the extent that benefits are payable under any automobile medical expense insurance or automobile no-fault plans;]

14. [Cosmetic surgery, except as the result of covered Injury occurring while this Policy is in force as to the Insured Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect;]

15. [Illness, Accident, treatment or medical condition arising out of hang-gliding, skydiving, glider flying, parasailing, sail planing, bungee jumping, racing or speed contests, skin diving, parachuting or bungi-cord jumping;]

16. [Correction of congenital defects except as specifically provided;]

17. [Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law;]

18. [Services incurred prior to the Insured Person's Effective Date or during Hospital Confinement in one or more facilities which began prior to the Insured Person's Effective Date;]

19. [Expense incurred as the result of dental treatment, except as provided in the Sickness Dental Expense Benefit, if included in this Policy. This exclusion does not apply to treatment resulting from Injury to natural teeth;]

20. [Expense incurred for treatment of temporomandibular joint dysfunction and associated myofacial pain, except as specifically provided;]

21. [Expense incurred after the date insurance terminates for an Insured Person except as may be specifically provided in the Extension of Benefits Provision, when applicable;]

22. [Medical services that are not Medically Necessary or that do not conform with medical standards of practice within the community. Also services and supplies in connection with Experimental or Investigational Care for the terminally ill;]

23. [Injury or Sickness resulting from declared or undeclared war; or any act thereof;]

24. [Charges for treatment of any Injury or Sickness due to an Insured Person's commission of, or attempt to commit a felony, or a crime which would be considered a felony if prosecuted;]

25. [Injury due to participation in a riot;]

26. [Charges for which Insured Persons have no legal obligation to pay in absence of this or like coverage;]

27. [For services or supplies rendered by a close relative of the Insured Person. By “close relative” We mean an Insured Person’s spouse, children, parents, brothers and sisters;]

28. [Personal hygiene/convenience items; telephone consultations, missed appointments, photocopies or medical records, or completion of claim forms; expenses incurred for custodial care or services not needed to diagnose or treat an Injury or Sickness, including but not limited to services related to the activities of daily living;]

29. [For services, supplies or treatment, including any period of Hospital Confinement, which were not recommended, approved and certified as necessary and reasonable by a Doctor; or expenses non-medical in nature;]

30. [Expenses incurred in connection with foot care only to improve comfort or appearance such as care for weak, strained or flat feet; subluxation; corns; calluses; bunions, except open cutting operations; routine care of toenails, except for the removal of the nail root and necessary services in treatment of metabolic or peripheral-vascular disease; treatment of the instability and imbalance of the feet; and any tarsalgia, metatarsalgia. Expenses incurred for the care and treatment of Injury, infection, or disease are not excluded;]

31. [Screening examinations, including X-ray examinations made without film, except as specifically provided;]

32. [Expenses incurred in connection with family planning, the enhancement of fertility, fertility tests, correction of infertility, in-vitro fertilization, artificial insemination, and services or supplies for inducing conception;]

33. [Expenses incurred in connection with a voluntary sterilization procedure or any sterilization reversal process;]

34. [Inpatient charges for physical therapy or diagnostic services if physical therapy and diagnostic services are available on an outpatient basis;]

35. [Physical therapy unless recommended by the Student Health Center;]

36. [Treatment of obesity, including any care which is primarily dieting or exercise for weight loss, except for surgical treatment of morbid obesity;]

37. [Expenses incurred for transsexual surgery or any treatment leading to or in connection with transsexual surgery;]

38. [Marriage, family, and group counseling;]

39. [Services or supplies primarily for educational, vocational or training purposes, except the initial visit to diagnose and determine if a medical condition is causing a learning disability;]

40. [Expense incurred for eye examinations or prescriptions, eyeglasses, and contact lenses (except for sclera shells which are intended for use of corneal bandages), eye refractions, vision therapy, multiphasic testing, or lasix or other vision procedures except as required for repair caused by a covered Injury;]

41. [Well baby care, including routine exams and immunizations, except as specifically provided;]

42. [Routine periodical physical examinations [and routine chest x-rays], except as specifically provided;]

43. [Expenses incurred for allergy testing [and allergy treatment];]

44. [Treatment provided in a governmental Hospital unless there is a legal obligation to pay such charges in the absence of insurance;]

45. [Blood plasma, except charges by a Hospital for the processing or administration of blood;]

46. [Expenses for any service or supply not specified in this Policy as a covered service;]

47. [An amount of a charge in excess of the Reasonable and Customary Expense;]

48. [Elective Treatment or elective surgery, except as specifically provided;]

49. [Services not Medically Necessary;]

50. [Oral contraceptives and other forms of contraception used for contraceptive purposes only, except as specifically provided;]

51. [Expenses for emergency room treatment for an Injury or Sickness not a Medical Emergency as defined in this Policy, including emergency "follow-up" visits;]

52. [Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route;]

53. [Treatment of mental or nervous disorders except as specifically provided;]

54. [Treatment of alcohol and substance abuse except as specifically provided;]

55. [For International Students, expenses incurred within the Insured Person's Home Country or Country of regular domicile;]

56. [[In Missouri - suicide, attempted suicide, or intentionally self-inflicted injury only while sane;] **[**Suicide, attempted suicide, or intentionally self-inflicted injury [while sane, or insane except in Missouri;]]]

57. [Injuries incurred by the Insured Person while intoxicated or under the influence of any drug unless taken as prescribed by a Doctor;]

58. [Expense incurred for: [tubal ligation;][vasectomy;] breast implants; breast reduction; sexual reassignment surgery; impotence (organic or otherwise); non-cystic acne; non-prescription birth control; submucus resection and/or other surgical correction for deviated nasal septum, other than for required treatment of acute purulent sinusitis; circumcision; gynecomastia; hirsutism; [and learning disabilities or disorders or Attention Deficit Disorder;]]

59. [Voluntary or elective abortion; [pregnancy of a dependent child], except as specifically provided;]

60. [Expense incurred for any service, treatment or supply for the diagnosis or treatment of sexual dysfunction (including erectile dysfunction). This includes, but is not limited to, drugs [except as noted], laboratory and x-ray tests, counseling, transsexual procedures or penile prostheses necessary due to any medical condition or organic disease. A penile prosthesis will be eligible for payment only after prostate surgery; [Doctor-prescribed Viagra will be limited to six (6) tablets per month];]

61. [Illegal drugs;]

62. [Medicines not taken in the dosage or for the purpose prescribed by the Insured Person's Doctor;]

63. [Expense incurred for: topical acne treatments, moles, non-malignant warts or lesions, fertility medication; legend vitamins or food supplements; smoking deterrents; immunization agents; biological sera; drugs to promote or stimulate hair growth; experimental drugs; drugs dispensed in a rest home or hospital, except as provided under the Hospital Expense Benefit;]

64. [Expenses incurred for any experimental drug or drug combination which the Federal Food and Drug Administration (FDA) has not approved for any indication, or for any drug which the FDA has determined to be contraindicated for a particular condition;]

65. [Testing, treatment, or services for any condition in the absence of Sickness or Injury except as specifically provided;]

66. [Expenses incurred for replacement braces and appliances, except for repair or replacement that is required by a changed condition due to Sickness or Injury;]

67. [Spinal manipulation, including adjustment and other chiropractic-type services;]

68. [Alternative health care, including (but not limited to) acupuncture, except as specifically provided, acupressure, biofeedback, reflexology, and rolfing type services;]

69. [Expenses incurred for services or supplies for the diagnosis and treatment of sleep disorders, including but not limited to apnea monitoring and sleep studies;]

70. [Hearing aids, including exams for fitting, except as required to correct damage caused by an Injury which occurs while the patient is covered by this Plan, provided they are obtained within four months of the date of the Injury;]

71. [Services, supplies and facility that are provided mainly for a rest cure, maintenance or custodial care;]

72. [Expense for hair replacement, wigs or wig maintenance;]

73. [Services that have already been paid by another insurance carrier, even if those services would have otherwise been covered by this Plan;]

74. [Any treatment, service or supply in excess of the maximum benefit specified in this Policy;]

75. [Care, treatment or supplies furnished by a program or agency funded by any government;]

76. [Hospital inpatient admissions primarily for diagnostic studies when bed care is not Medically Necessary;]

77. [Professional services billed by a Doctor or nurse who is an employee of a hospital or skilled nursing facility, and who is paid by that facility for the service;]

78. [Nicotine addiction;]

79. [Patient controlled anesthesia.]

Limitation for Pre-Existing Conditions
We [will not pay *or* will pay up to {$500 to $2,500} of] benefits for any expenses Incurred for treatment of an Insured Person's Pre-Existing Condition until he has been insured under this Policy;

1. if he enrolled for coverage within {30} days after he first became an Eligible Person, a continuous period of 12 months; or
2. if he enrolled for coverage more than {31} days after he first became an Eligible Person, a continuous period of 18 months.

Any period during which benefits are not payable for a Pre-Existing Condition will be reduced by the number of months during which the Insured Person was insured by another similar health care plan under which coverage ended not more than 60 days before he became insured under this Policy. This 60-day period will be extended by the number of days in any applicable Waiting Period shown in the *Schedule of Benefits*, as long as the Eligible Person has completed any required enrollment before the end of the Waiting Period.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES. The entire contract is made up of: (a) this Policy, including Your Application; and (b) the individual applications, if any, of Insured Persons. Statements made by the Policyholder, Policyholder or an Insured Person shall be deemed to be representations and not warranties. No such statement may be used in any contest of this insurance, unless the statement: (1) is contained in writing and signed by the applicant; and (2) a copy has been given to such person, or to his/her beneficiary. No change in this Policy shall be valid unless approved by an officer of Ours. It must be evidenced by endorsement on this Policy, or by amendment of this Policy signed by the Policyholder and Us. No agent has authority to change this Policy or to waive any of its provisions.

GRACE PERIOD. A grace period of thirty-one days will be granted for the payment of each premium falling due after the first premium. During that period, this Policy shall continue in force. You shall be liable to Us for the payment of the premium for the period this Policy continues in force.

NOTICE OF CLAIM. Written notice of claim must be given to Us within {30} days after the occurrence or commencement of any Loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant or the beneficiary to Us at Our Administrative Office or to any authorized agent, with information sufficient to identify the Insured Person, shall be deemed notice to Us.

CLAIM FORMS. Upon receipt of a written notice of claim, We will give the claimant such forms as are usually given by Us for filing proof of Loss. If such forms are not given within 15 days after receipt of such notice, he or she can fulfill the terms of this Policy as to proof of Loss by giving written proof of: (a) the occurrence of the Loss; (b) the nature of the Loss; and (c) the extent of the Loss.

PROOF OF LOSS. Written proof of Loss must be given to Us at Our Home Office within **{**90} after the date of such Loss. Failure to give such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, proof must be given as soon as reasonably possible and in no event later than one year.

TIME PAYMENT OF CLAIMS. Benefits payable under this Policy shall be paid as they accrue and as soon as due written proof of such Loss has been received by Us.

PAYMENT OF CLAIMS. All benefits for Loss other than death, will be paid to the Insured Student. All or a portion of the benefits, if any, provided by this Policy may be paid directly to the Hospital or person rendering such services. It is not required that the service be rendered by a particular Hospital or person. The Insured Person must make a written request to Us before We can do this. We must receive the request no later than the time for filing proof of Loss. Death benefits, if any, will be paid to the beneficiary chosen by the Insured Student. This choice must be in writing and filed with Us. If the Insured Student has not chosen a beneficiary, or if there is no beneficiary alive when the student dies, We will pay:

(a) his/her parents or legal guardian, if a minor;
(b) otherwise, We will pay his/her estate.

Benefits payable under the Policy to the Insured Student will be paid with or without an assignment from the Insured Student, to public Hospitals or clinics for services and supplies provided to an Insured if a proper claim is submitted by the Public Hospital or clinic. No benefits will be paid under the Policy to the public Hospital or clinic if such benefits have been paid to the Insured Student prior to Our receiving the claim. Payment of benefits to such public Hospital or clinic will discharge Us from all liability to the extent of any such payment.

We will pay these benefits immediately upon receipt of due written proof of such Loss.

Covered Charges paid on behalf of an Insured Person will be paid to the human services department when:

(a) the human services department has paid or is paying benefits on behalf of such person under the State's medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.;
(b) payment for the services in question has been made by the human services department to the medicaid provider; or
(c) We are notified that such person receives benefits under the medicaid program and that benefits must be paid directly to the human services department.

PHYSICAL EXAMINATION. At Our own expense, We have the right to have a Doctor examine an Insured Person when and so often as We deem reasonably necessary while there is a claim pending under this Policy. We have the right to conduct an autopsy in case of death where it is not prohibited by law.

LEGAL ACTIONS. No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the Policy and that no such action shall be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Policy

RECORDS MAINTAINED. You shall maintain records of each person insured. The records shall show all data that is needed to administer this Policy.

EXAMINATION AND AUDIT. We shall be allowed to examine and audit Your books and records which pertain to this Policy at reasonable times. We may also be allowed to do this within three (3) years after the later of: (a) the date this Policy terminates; or (b) until final settlement of all claims hereunder.

CERTIFICATES OF INSURANCE. Where required by law, a certificate of insurance will be delivered to the Policyholder for delivery to each Insured Student. The certificate will list the benefits, conditions and limits of the Policy and will state to whom benefits will be paid.

[CONFORMITY WITH STATE STATUTES. Any provision of this Policy which, on the Policy Effective Date, is in conflict with the statutes of the state in which the Insured Person resides on such date, is hereby amended to conform to the minimum requirements of such statutes.]

[PREMIUM REFUND POLICY. If an Insured Student withdraws from the university within the first {ten (10)} days of the first semester, and has not yet submitted a claim, he or she will receive a full refund of the insurance premium. If an Insured Student withdraws from the university after{ten (10)} days of the first semester, his or her coverage will remain in effect until the end of the term for which he or she was charged premium. If the Insured Student withdraws: (a) other than due to entering any military service; and (b) after the first {ten (10)} days of the semester, no premium refund will be made.

Those Insured Students withdrawing from school to enter military service will be entitled to a pro-rata refund of premium upon written request of the withdrawal from school, and coverage will end as of the date of such entry.]

[The Insured Person may cancel their coverage with {ten (10)} working days of the Effective Date of coverage by submitting a request for cancellation in writing to the university. Under no circumstances will a cancellation refund be provided if the Insured Person has filed a claim with Us.]

COORDINATION OF BENEFITS

This section will be used to determine an Insured Person's benefits under this Policy IF:

the Insured Person is insured for medical care benefits under this Policy and is also covered for these benefits under other Plans,
and
the benefits that would be paid by this Policy, without this section
PLUS
the benefits that would be paid by the other Plans, without a section similar to this section
WOULD EXCEED ALLOWED EXPENSES as defined below.

DEFINITIONS:

PLAN means a plan which provides benefits or services for, or by reason of, hospital, surgical, medical, or dental care or treatment through:

1. group, blanket or franchise insurance coverage; this does not apply to blanket school accident only coverages;

2. pre-paid plans for:
   - group hospital service;
   - group medical service;
   - group practice;
   - Individual practice; and
   - any other such plans for members of a group;
3. any plan provided by:
   - labor management trusts;
   - unions;
   - employer organizations;
   - professional organization; or
   - employee benefit organizations;
4. a government program, or statute, other than a state medical assistance plan that implements Title XIX of the Social Security Act of 1965;
5. any group or group type hospital indemnity of more than $200.00 per day;
6. Medicare (Title XVIII of the Social Security Act); and
7. any part of a state auto reparation or indemnity act (no fault insurance) with which the state permits coordination.

Plan does not include individual or family policies; individual or family subscriber contracts except as stated. Nor does it include any group or group type hospital indemnity or medical payment benefits customarily included in the traditional automobile contracts.

THIS PLAN means the medical care benefits provided by this Policy.

ALLOWED EXPENSE means an expense which is:
- necessary, reasonable and customary;
- incurred while the person (for whom the claim is made) is insured, or is entitled to benefits after insurance ends, under this Policy; and
at least partly covered under one of the plans covering such Insured Person.

When this plan does not pay its benefits first, Allowed Expense will not include an expense which is not paid because of the claimant's failure to comply with the cost containment requirements of the plan which pays its benefits first.

When a plan provides a benefit as a service rather than a cash payment, the reasonable cash value of the service will be considered to be both an allowed expense and a benefit paid.

EFFECT ON BENEFITS UNDER THIS PLAN

When this section is used, the rules listed below will determine the amount of benefit each plan will pay. All benefits will be determined on a calendar year basis.

These rules may require this plan to pay its benefits first. If so, this plan will pay its full benefits without taking into account other plan benefits. These rules may require one or more of the other plans to pay their benefits before this plan. If so, this plan will reduce its benefits so that in any calendar year, the sum of all benefits to be paid to a person (by this and all other plans) equals the allowed expenses for that year. Benefits to be paid under other plans include benefits that would be paid if proper claim is made for such benefits.

RULES TO DETERMINE WHICH PLAN PAYS FIRST

A plan, or part of one, that does not have a section similar to this section will pay its benefits before a plan that has such a section.

In all other cases, the plan that will pay its benefits first will be:

1. The plan which covers the Insured Person as an employee rather than as a full or part-time student. Item 1 will not apply unless a similar provision is contained in all plans. In this case item 2, 3 or 4 will determine which plan pays first.
2. If 1 does not apply, the plan which covers the person as a full or part-time student rather than as a dependent.
3. If 1 and 2 do not apply, the plan which covers the person as a dependent of the parent whose month and date of birth occurs earlier in the year. If the other plan has a rule based on the gender of the parent, the gender rule will determine the order of benefits. However, a child's parents may be divorced or separated. If so, the plan to pay its benefits first will be the plan which covers the child as a dependent of the parent with custody rather than as a dependent of the parent without custody. If the parent with custody remarries:
   - the plan which covers the child as a dependent of a parent with custody will pay its benefits first;
   - the plan which covers the child as a dependent of a stepparent will pay its benefits next; and
   - the plan which covers the child as a dependent of a parent without custody will pay its benefits last.

A court decree may require the parent without custody to be financially responsible for the child's health care. If so, the plan to pay its benefits first will be the plan which covers the child as a dependent of the parent with such responsibility rather than as a dependent of any other person.

4. If 1, 2, or 3 do not apply, the plan which has covered the insured person for the longer time rather than the shorter time.

If the benefits of this plan are reduced due to these rules, such reduction will be done in proportion. Any benefits paid by this plan on a reduced basis will be charged against the benefit limits of this plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For this section to work, We must exchange information with other plans. To do so, We may give to, or get from any source all such information necessary. This will be done without the consent of or notice to any person. Any person claiming benefits under this plan must give to Us the required information.

FACILITY OF PAYMENT

Another plan may pay a benefit that should be paid by Us by terms of this section. If this happens, We may pay to such payor the amount required for it to satisfy the intent of this section. This will be done at Our discretion. Any amount so paid will be considered a benefit under this plan. We will not be liable for such payment after it is made.**]**

[**APPEALS PROCEDURE**

If a claim is wholly or partially denied, a written notice will be sent to the Insured Person containing the reason for the denial. The notice will include a reference to the provision in the Plan description and a description of any additional information which might be necessary for reconsideration of the claim. The notice will also describe the right to appeal. A written appeal, along with any additional information or comments, may be sent within 6 months after notice of denial. In preparing the appeal, the Insured Person, or his or her representative, may review all documents related to the claim and submit written comments and issues related to the denial. After the written notice is filed and all relevant information is presented, the claim will be reviewed and a final decision sent within 60 days after receipt of the notice of the appeal. Under special circumstances, an extension for further review will be granted, but not for longer than 60 additional days.]

[EXCESS AND PRIMARY EXCESS] PROVISION

[EXCESS PROVISION

No benefit under this Policy is payable for any Expense incurred for Injury or Sickness which is paid or payable by other valid and collectible insurance except under an automobile insurance policy.

Covered Medical Expenses exclude amounts not covered by the primary carrier due to penalties imposed on the Insured Person for failing to comply with policy provisions or requirements.**]**

[PRIMARY EXCESS PROVISION

[After We pay an initial amount as shown in the *Schedule of Benefits*, no benefits in excess of this initial amount are payable under this Policy for any Expense incurred for Injury or Sickness which is paid or payable by other valid and collectible insurance except under an automobile insurance policy.]

[This Plan of insurance is primary for Student Health Center charges. Otherwise this Plan of insurance is secondary to any benefits paid or payable by other valid and collectible insurance, except under an automobile insurance policy. Benefits paid or payable by other valid and collectible insurance include benefits that would have been received had a claim for benefits been duly made therefor.]

Covered Medical Expenses exclude amounts not covered by the primary carrier due to penalties imposed on the Insured Person for failing to comply with policy provisions or requirements.**]]**

QBE INSURANCE CORPORATION
Administrative Office
Wall Street Plaza, 88 Pine Street, 16th Floor
New York, New York 10005

APPLICATION FOR BLANKET STUDENT ACCIDENT AND SICKNESS INSURANCE
Accidental Death and Accident and Sickness Medical Benefits

Part I Proposed Policyholder-School

a. Full Legal Name of Proposed Policyholder

_____

Name of Policyholder's Insurance Plan

b. _____

c. Address

_____

c. Requested Effective Date _____

Policy will become effective on the Requested Effective Date only if (a) all required information is provided and (b) QBEIC has received the initial premium on or before that date.

Policy terminates on _____

e. Eligible Students must be enrolled for _____ credit hours during the Term of Coverage checked below.

e. Eligible Student's Term of Coverage

- ☐ **Full Year**
- ☐ **School Year**
- ☐ **Other** _____

Coverage is:

- ☐ **Mandatory for Student**
- ☐ **Mandatory /Hard Waiver for Student**
- ☐ **Voluntary for Student**
- ☐ **Available for Eligible Dependents**

Part II Plan of Insurance and Premium Rates

The Plan of Insurance and the Premium Rates for it are are shown on the Proposal for Insurance presented by QBE Insurance Corporation to the Applicant. Any policy issued by QBE in consideration of this Application and payment of the first premium will include only those benefits shown in the Proposal for Insurance and agreed to by it and the Applicant.

Part III Acknowledgements and Signatures

a. Fraud Warning Any person who, knowingly and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information, may be guilty of insurance fraud.

b. Applicant's Acknowledgement I, the applicant, declare, to the best of my knowledge and belief, that all statements and answers in this application are true and complete. I understand and agree that (a) this application will form part of any policy issued, (b) no information given to or acquired by any representative of QBEIC will bind it, unless it is in writing on this application, (c) no waiver or modification will bind the Company unless it is in writing and is signed by an executive officer of QBEIC, and (d) only those persons eligible under the terms of an issued policy will be insured.

Applicant Acknowledges that the insurance applied for is designed tosupplement rather than replace facilities and services available at Applicant's Student Health Center.

Dated at _____ **on the** _____ **day of** _____ **, 20** _____

_____ _____

Signed for the Proposed Policyholder *Signed by Licensed Agent*

Title _____ *Agent License Number* _____

This Application must be accepted, as indicated by the signature of its authorized representative below, by QBE Insurance Corporation before coverage will become effective.

Application Accepted for the Company by:

_____ Policy Number Assigned: _____

Name, Title

On: _____

Date

For residents of Arkansas:

ARKANSAS INSURED'S ACCESS TO INSURER INFORMATION: This notice is to comply with Arkansas House Bill 1221. We are required by law to notify You of the complete addresses and phone numbers of the Arkansas Insurance Department, the insurance company's servicing office, and the agent. Below is this information:

Arkansas Insurance Department, Consumer Services Division, 1200 W. Third Street, Little Rock, AR 72201-1904 Telephone: 1-800-852-5494

Servicing Office:

[QBE Insurance Corporation
Wall Street Plaza
88 Pine Street
New York, NY 10005
Tel: 800-XXX-XXXX]

SERFF Tracking Number:	*CLTR-125887441*	*State:*	*Arkansas*
Filing Company:	*QBE Insurance Corporation*	*State Tracking Number:*	*41028*
Company Tracking Number:	*BAS-08-1000.00*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.001 Student*
Product Name:	*Blanket Student Medical Insurance*		
Project Name/Number:	*BAS-08-1000.00/BAS-08-1000.00*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CLTR-125887441*	*State:*	*Arkansas*
Filing Company:	*QBE Insurance Corporation*	*State Tracking Number:*	*41028*
Company Tracking Number:	*BAS-08-1000.00*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.001 Student*
Product Name:	*Blanket Student Medical Insurance*		
Project Name/Number:	*BAS-08-1000.00/BAS-08-1000.00*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice

Review Status: Approved-Closed 12/12/2008

Comments:

Attachment:

FLESCH CERT.doc.pdf

Satisfied -Name: Application

Review Status: Approved-Closed 12/12/2008

Comments:

see forms schedule

Satisfied -Name: Authorization to File

Review Status: Approved-Closed 12/12/2008

Comments:

Attachment:

Coulter Filing Authority.pdf

FLESCH CERTIFICATION

I, Harriet Ladd, Assistant Vice President, Health Compliance, for QBE Insurance Corporation, certify that the form listed below satisfies the NAIC Model Bill standards of policy language simplification legislation.

Form Number	Form Title	Flesch Score
BAS-08-1000.00 et al	Blanket Student Medical Policy	46.1

Signature: H. Harriet Ladd

Date:

QBE
Specialty
Insurance

LETTER OF FILING AUTHORITY

November 3, 2008

RE: QBE Insurance Corporation – NAIC # 0796-39217
Student Medical – Accident and Sickness Program

To Whom It May Concern,

This letter will certify that Coulter and Associates, Inc. has been given the authorization to submit this rate, rule and/or form filing on behalf of QBE Insurance Corporation (part of QBE Specialty Insurance). This authorization includes providing additional information and responding to questions regarding this filing as necessary.

Please direct all correspondence and inquiries related to this filing directly to Coulter and Associates,Inc.

Please feel free to contact me at 419-747-9922 or by email at pamela.alt@qbeamericas.com with any questions regarding this filing authorization.

Pamela Alt
Signature

PAMELA ALT – VP COMPLIANCE
NAME & TITLE

2230 Village Mall Drive, Suite A • Mansfield, Ohio 44906
Phone: 419.747.9933 • Fax: 419.747.9944 • *www.qbe.com*

SERFF Tracking Number:	*CLTR-125887441*	*State:*	*Arkansas*
Filing Company:	*QBE Insurance Corporation*	*State Tracking Number:*	*41028*
Company Tracking Number:	*BAS-08-1000.00*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.001 Student*
Product Name:	*Blanket Student Medical Insurance*		
Project Name/Number:	*BAS-08-1000.00/BAS-08-1000.00*		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Blanket Student Accident and Sickness Policy	11/25/2008	AR BAS-08-100000 Policy Clean.pdf

QBE INSURANCE CORPORATION

Administrative Office
Wall Street Plaza, 88 Pine Street, 16th Floor
New York, NY 10005

POLICYHOLDER:	{ABC University}
GROUP POLICY NUMBER:	{XXX123456}
POLICY EFFECTIVE DATE:	{January 1, 2009}
POLICY ISSUE DATE:	{January 1, 2009}
include when Policy Term is greater than one year **POLICY ANNIVERSARY DATE:**	{January 1}
POLICY TERM	{January 1, 2009 through December 31, 2009}
STATE OF ISSUE:	{Arkansas}

QBE Insurance Corporation agrees to provide the benefits shown in the Plan of Insurance with respect to each person insured for them under this Policy. The benefits will be paid in accordance with the provisions of this Policy.

This Policy is issued in consideration of: (a) the attached application; and (b) the payment of premiums as set forth herein.

This Policy takes effect as of 12:01 a.m. on its Policy Effective Date, at the Policyholder's address. This Policy terminates at 12:00 a.m. on the day following the last day of the Policy Term if premium is paid according to agreed terms.

The provisions on the pages which follow form a part of this Policy. This Policy is issued at the Administrative Office of Insurance Company in New York .

For Insurance Company

President Secretary

• BLANKET STUDENT ACCIDENT AND SICKNESS POLICY •
• NON-PARTICIPATING •

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

This policy is intended to read in its entirety. In order to understand al the conditions, exclusions and limitations applicable to its benefits, please read all the policy provisions carefully.

Eligible Persons: All full-time students of the Policyholder who {are enrolled for {12} credit hours or more per {semester; quarter}}

Dependents of Insured Students, as defined in the *Definitions* section of this policy

[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Principal Sum	{$1,000 to $25,000}
Loss must occur within	{180 to 365} days of the Covered Accident

Schedule of Covered Losses

Covered Loss	**Benefit**
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of One Hand or Foot and Sight in One Eye	100% of the Principal Sum
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing in Both Ears	50% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum]

PLAN OF INSURANCE

This section will appear if a Policyholder elects a the PPO Plan; otherwise the Indemnity section below will appear.
[Preferred Provider Organization Plan

To locate a Network Provider in Your area, consult Your Provider Directory **[**or call toll free **[**xxx-xxx-xxxx**] [**or visit Our website at **[**##@###.com**]]**.

Benefits will be provided only for the coverages indicated below and will be paid only up to the amounts shown. Benefits are not provided for coverages marked "Nil'.

{Lifetime; Policy Year} Maximum Benefit:
Per Insured Person: {$1,000 - $500,000}

[Per Condition Aggregate Maximum per Injury or Sickness:
Per Insured Person: {$1,000 - $500,000}]

[Per Policy Year Aggregate Maximum per Injury or Sickness:
Per Insured Person: {$1,000 - $500,00}]

[Deductible

applies to:	each {condition, Policy Year}
Network Provider:	{$0 - $150.00} per Insured Student {$0 - $1,000.00} per Insured Dependent
Non-Network Provider	[$250 - $1,000} per Insured Person {$750-$3,000} per Family (3 per family)] {$250 - $1,000} per Insured Student {$250 - $1,000} per Insured Dependent]

[Out-of-Pocket Maximum per Policy Year:

Network Provider:	{$1,000 – unlimited} per Insured Person
Non-Network Provider:	{$1,000 – unlimited} per Insured Person]

[Amount of Insurance { $100-$200 }

COVERAGE	BENEFIT AMOUNT
HOSPITAL EXPENSE BENEFIT	
Hospital Room & Board Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
Miscellaneous Hospital Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]
SURGICAL EXPENSE BENEFITS (INPATIENT OR OUTPATIENT)	
Surgery Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]
Multiple Surgical Procedure Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]
[Anesthesia Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
[Assistant Surgeon Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance up to {20}% of the Surgical Expense paid [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C up to {20}% of the Surgical Expense paid [, subject to Deductible]]
[Second Surgical Opinion Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
IN-HOSPITAL DOCTOR'S FEES AND MEDICAL EXPENSE BENEFIT	
Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]

Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]

OUTPATIENT EXPENSE BENEFIT

[Doctor's Office Visit Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
[Doctor's Office Visit Expense Copayment:	
Network Provider:	{$10 - $25] per visit
Non-Network Provider:	{$50 - $75] per visit]
[Chiropractic Care Office Visit Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
[Chiropractic Care Office Visit Expense Benefit Maximum:	{three (3)} visits per Policy Year]
[Hospital Outpatient Department Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
[Emergency Room Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Copayment:	{$50 - $150} without a referral; { $25 - $7} with a referral
Non-Network Provider:	{70% - 90%} of R & C for a Medical Emergency [, subject to Deductible] {60% - 70%} of R & C for all other [, subject to Deductible] [for visits resulting in a hospital admission]
Copayment:	{$50 - $75} [visits that do not require a hospital admission]]
[Diagnostic X-ray and Laboratory Testing Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
[Physical Therapy Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
[Physical Therapy Expense Benefit Maximum:	{$50.00} per visit, maximum of {$900.00} per Policy Year]
[Occupational Therapy Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
[Occupational Therapy Expense Benefit Maximum:	{$50} per visit, maximum of {$900} per Policy Year The combined maximum benefit for Occupational and Physical Therapy is {$900} per Policy Year]
[Speech Therapy Expense Covered Percentage:	
Network Provider:	{80% - 100} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
[Acupuncture Expense Covered Percentage:	
Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
[Acupuncture Expense Benefit Maximum:	{$500} per Policy Year [, subject to Deductible]]
[Immunization Expense Covered Percentage:	{100%} of R & C at the Student Health Center only]

[Allergy Testing and Allergy Extracts Expense Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[High Cost Procedure Expense covered percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
[High Cost Procedure Benefit Maximum:	up to {$1,500} per procedure [, subject to Deductible]]

[MATERNITY EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[OPTIONAL MAMMOGRAPHIC EXAMINATION EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[PELVIC, CERVICAL, PROSTATE AND COLORECTAL EXAM EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[ABORTION EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%] of the Preferred Allowance [, subject to Deductible]]
Non-Network Provider:	{60% - 80%] of R & C [, subject to Deductible]]]

[ACCIDENTAL DENTAL INJURY EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) VACCINE EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

OR

[Copayment	Brand Name Drugs: {$10 - $40} per prescription
Copayment	Generic Drugs: {$5 - $20} per prescription
Benefit Maximum:	{$50} per condition – Plan Maximum
Benefit Maximum:	{$50 per policy year – Plan Maximum**]**

[AMBULANCE EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[CONSULTANT EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[HOME HEALTH CARE EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]
Benefit Maximum:	{100} visits per calendar year]]

[LICENSED NURSE EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[OPTIONAL HOSPICE EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]
Lifetime Benefit Maximum:	{$4,000}]

[PRE-ADMISSION TESTS EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[PRESCRIPTION DRUG EXPENSE BENEFIT

Copayment:	Brand Name Drugs:	{$20} per prescription
	Generic Name Drugs:	{$12} per prescription
Benefit Maximum:		{$3,000}]

[PROSTHETICS APPLIANCE & ORTHOTIC DEVICE EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[SICKNESS DENTAL EXPENSE BENEFIT
Covered Percentage:
Network Provider: {80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider: {60% - 80%} of R & C [, subject to Deductible]]

[SKILLED NURSING FACILITY EXPENSE BENEFIT
Covered Percentage:
Network Provider: {80% - 100} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider: {60% - 80%} of R & C [, subject to Deductible]]

[STUDENT HEALTH CENTER REFERRAL Included]

[EMERGENCY MEDICAL EVACUATION EXPENSE BENEFIT
Covered Percentage: {100%} of actual Expense [, subject to Deductible]]
Benefit Maximum: {$15,000}]

[REPATRIATION OF BODY REMAINS EXPENSE BENEFIT
Covered Percentage: {100%} of actual Expense [, subject to Deductible]
Benefit Maximum: {$15,000}]

[CHILD IMMUNIZATION EXPENSE BENEFIT
Covered Percentage: Network Provider: {100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider: {100%} of R & C [, subject to Deductible]]

[DENTAL ANESTHESIA AND HOSPITALIZATION EXPENSE BENEFIT
Covered Percentage:
Network Provider: [{80% - 100} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider: {60% - 80%} of R & C [, subject to Deductible]]

[ENTERAL FORMULA EXPENSE BENEFIT
Covered Percentage:
Network Provider: {80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider: {60% - 80%} of R & C [, subject to Deductible]]

[BREAST RECONSTRUCTION AFTER MASTECTOMY EXPENSE BENEFIT
Covered Percentage:
Network Provider: {80% - 100} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider: {60% - 80%} of R & C [, subject to Deductible]]

[NEWBORN HEARING SCREENING EXPENSE BENEFIT
Covered Percentage:
Network Provider: {80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider: {60% - 80] of R & C [, subject to Deductible]]

[OSTEOPOROSIS EXPENSE BENEFIT
Covered Percentage:
Network Provider: {80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider: {60% - 80%} of R & C [, subject to Deductible]]

[OPTIONAL CHILD HEALTH SUPERVISION EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

BREAST CANCER EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]

LOSS/IMPAIRMENT OF SPEECH/HEARING EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]

DIABETES EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]

LEAD POISONING TESTING EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]

[OPTIONAL CHEMICAL DEPENDENCY AND MENTAL ILLNESS EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
Benefit Maximum per Policy Year	{$2,000}

[OPTIONAL ALCOHOLISM TREATMENT EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]
Benefit Maximum per Policy Year	{$6,000}]

[LARYNGECTOMY EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[RECONSTRUCTIVE SURGERY EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[SEVERE MENTAL ILLNESS AND SERIOUS EMOTIONAL DISTURBANCES OF CHILDREN EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[SIGMOIDOSCOPIC EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]
Benefit Maximum:	{$3,000}]

[OPTIONAL TEMPOROMANDIBULAR JOINT / CRANIOMANDIBULAR DISORDER EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]
Benefit Maximum:	{$3,000} lifetime maximum]

[TREATMENT OF MORBID OBESITY EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]
Benefit Maximum:	{$3,000} lifetime maximum]

[CLINICAL TRIALS FOR PREVENTION, EARLY DETECTION AND TREATMENT OF CANCER EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]

[ANNUAL ROUTINE EXAM EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%}] of R & C [, subject to Deductible]
Benefit Maximum:	{$150}]

[BREAST IMPLANT REMOVAL EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

INFERTILITY EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]

[MASTECTOMY EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[PEDIATRIC PREVENTIVE CARE EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[POST-MASTECTOMY EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[PROSTATE-SPECIFIC ANTIGEN EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]]

[CANCER CLINICAL TRIAL EXPENSE BENEFIT

Covered Percentage:

Network Provider:	{80% - 100%} of the Preferred Allowance [, subject to Deductible]
Non-Network Provider:	{60% - 80%} of R & C [, subject to Deductible]**]**

[DAY SURGERY MISCELLANEOUS EXPENSE BENEFIT

Covered Percentage:

Network Provider:	[[80% - 100%] of the Preferred Allowance [, subject to Deductible]]
Non-Network Provider:	[[60%- 80%] of R & C [, subject to Deductible]]

[TELEMEDICINE MEDICAL SERVICE BENEFIT

Covered Percentage:

Network Provider:	[[80% - 100%] of the Preferred Allowance [, subject to Deductible]]
Non-Network Provider:	[[60%- 80%] of R & C [, subject to Deductible]]

PHENYLKETONURIA EXPENSE BENEFIT

Covered Percentage:

Network Provider:	[[80% - 100%] of the Preferred Allowance [, subject to Deductible]]
Non-Network Provider:	[[60%- 80%] of R & C [, subject to Deductible]]

PREVENTIVE CARE FOR DEPENDENT CHILDREN EXPENSE BENEFIT

Covered Percentage:

Network Provider:	[[80% - 100%] of the Preferred Allowance [, subject to Deductible]]
Non-Network Provider:	[[60%- 80%] of R & C [, subject to Deductible]]

INDEMNITY PLAN

Benefits will be provided only for the coverages indicated below and will be paid only up to the amounts shown. Benefits are not provided for coverages marked "Nil'.

Lifetime Maximum Benefit:

Per Insured Person:	{$1,000 -$500,000}
[Per Condition Aggregate Maximum per Injury or Sickness:	
Per Insured Person:	{$1,000 - $500,000}]
[Per Policy Year Aggregate Maximum per Injury or Sickness:	
Per Insured Person:	{$1,000 - $500,00}]
[Deductible per Policy Year:	{$100.00} per Insured Person]
[Deductible per [Injury] [or Sickness]:	{$100.00} per Insured Person]
[Amount of Insurance	{ $100-$200 }

COVERAGE	**BENEFIT AMOUNT**
HOSPITAL EXPENSE BENEFIT	
Hospital Room & Board Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} the{0-90%} of R & C]
Benefit Maximum:	**{**$60} per day – Plan Maximum
Miscellaneous Hospital Expense Covered Percentage:	**{**80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
Benefit Maximum:	**{**$100} – Plan Maximum
SURGICAL EXPENSE BENEFITS (INPATIENT OR OUTPATIENT)	
Surgery Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
Benefit Maximum:	**{**$250} – Plan Maximum
Multiple Surgical Procedure Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
[Anesthesia Expense Covered Percentage:	{5%} of Surgical Expense Benefit paid – {100%} of Covered Charges]
[Assistant Surgeon Expense Covered Percentage:	{5%} of Surgical Expense Benefit paid – {100%} of Covered Charges]
[Second Surgical Opinion Expense Covered Percentage:	{5%} of Surgical Expense Benefit paid – {100%} of Covered Charges]
[IN-HOSPITAL DOCTOR'S FEES AND MEDICAL EXPENSE BENEFIT	
Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C
Benefit Maximum:	**{**$10} per visit -- Plan Maximum]
OUTPATIENT EXPENSE BENEFIT	
[Doctor's Office Visit Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[Chiropractic Care Office Visit Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
[Chiropractic Care Office Visit Expense Benefit Maximum:	{$1,000} per Policy Year
[Hospital Outpatient Department Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
[Emergency Room Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
[Diagnostic X-ray and Laboratory Testing Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
[Diagnostic X-ray & Laboratory Testing Expense Copayment in addition to Plan Deductible:	{$0-$20}
[Diagnostic X-ray & Laboratory Testing Expense Benefit Maximum:	Plan Maximum]
[Physical Therapy Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
[Physical Therapy Expense Benefit Maximum:	{$1,000} per Policy Year **[**or {$75} per visit - Plan Maximum**]**
[Physical/Occupational Therapy Expense Maximum Visits:	{two (2) visits – 50 visits}
[Post-Surgical Physical Therapy Expense Benefit Maximum:	{$3,000} per Policy Year
[Occupational Therapy Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90} of R & C]
[Occupational Therapy Expense Benefit Maximum:	{$1,000} per Policy Year [or **{**$75} per visit -- Plan Maximum**]**
[Occupational Therapy Expense Maximum Visits:	{two (2) visits – 50 visits}]
[Speech Therapy Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
[Acupuncture Expense:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
[Immunization Expense Covered Percentage:	{80-100%} of R & C at the Student Health Center only]
[Allergy Testing and Allergy Extracts [Expense Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
[High Cost Procedure Benefit Maximum:	up to {$1,500} per procedure]

[MATERNITY EXPENSE BENEFIT
Covered Percentage: **{**80-100%} of R & C [up to the first {0-$5,000}; then {0-90%} of R & C]

[OPTIONAL MAMMOGRAPHIC EXAMINATION EXPENSE BENEFIT
Covered Percentage: **{**80-100%} of R & C [up to the first {0-$5,000} then {0-90} of R & C]

[PELVIC, CERVICAL, PROSTATE AND COLORECTAL EXAM EXPENSE BENEFIT
Covered Percentage: **{**80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[ABORTION EXPENSE BENEFIT {80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) VACCINE EXPENSE BENEFIT
Covered Percentage: {80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R& C]; *or*
Copayment Brand Name Drugs:
{$10 - $40} per prescription

Copayment	Generic Drugs: {**[**$5 - $20} per prescription
Benefit Maximum:	{$50} per condition – Plan Maximum
Benefit Maximum:	{$50} per policy year – Plan Maximum**]**

[ACCIDENTAL DENTAL INJURY EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]; *or* {$75} per tooth – Plan Maximum

[AMBULANCE EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[CONSULTANT EXPENSE BENEFIT

Covered Percentage:	**{**80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[HOME HEALTH CARE EXPENSE BENEFIT

Covered Percentage:	**{**80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
Benefit Maximum:	{100} visits per calendar year

[LICENSED NURSE EXPENSE BENEFIT	**{**80-100%] of R & C [up to the first [0-$5,000] then [0-90%] of R & C]
[OPTIONAL HOSPICE EXPENSE BENEFIT	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]]

[PRE-ADMISSION TESTS EXPENSE BENEFIT

Covered Percentage:	**{**80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[PRESCRIPTION DRUG EXPENSE BENEFIT

Covered Percentage:		{90%} at the Student Health Center {80%} of R &C elsewhere
Copayment	Brand Name Drugs:	{$100 - $40} per prescription
Copayment	Generic Drugs:	{$5 - $20 per prescription}
Benefit Maximum:		{$50 - Plan Maximum}]

[PROSTHETICS APPLIANCE & ORTHOTIC DEVICE EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]]

[SICKNESS DENTAL EXPENSE BENEFIT	{80-100%} of R & C [up to the first {0-$5,00} then {0-90%} of R & C]]

[SKILLED NURSING FACILITY EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[STUDENT HEALTH CENTER REFERRAL	Included]

[EMERGENCY MEDICAL EVACUATION EXPENSE BENEFIT

Covered Percentage:	{100%} of actual Expense
Benefit Maximum:	{$50,000}]

[REPATRIATION OF BODY REMAINS EXPENSE BENEFIT

Covered Percentage:	{100%} of actual Expense
Benefit Maximum:	{$25,000}]

[CHILD IMMUNIZATION EXPENSE BENEFIT

Covered Percentage:	{100%} of R & C]

[DENTAL ANESTHESIA AND HOSPITALIZATION EXPENSE BENEFIT

Covered Percentage:	{0-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[ENTERAL FORMULA EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {10-90%} of R & C]

[BREAST RECONSTRUCTION AFTER MASTECTOMY EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[NEWBORN HEARING SCREENING EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]]

[OSTEOPOROSIS EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]]

[OPTIONAL CHILD HEALTH SUPERVISION EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]]

BREAST CANCER EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

LOSS/IMPAIRMENT OF SPEECH/HEARING EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

DIABETES EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

LEAD POISONING TESTING EXPENSE BENEFIT

Covered Percentage:	{80-100%] of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[OPTIONAL CHEMICAL DEPENDENCY AND MENTAL ILLNESS EXPENSE BENEFIT

Covered Percentage:	{80%} of R & C
Benefit Maximum per Policy Year	{2,000}]

[OPTIONAL ALCOHOLISM TREATMENT EXPENSE BENEFIT

Covered Percentage:	{80} of R & C
Benefit Maximum per Policy Year	{$6,000}]

[LARYNGECTOMY EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]]

[RECONSTRUCTIVE SURGERY EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]]

[SEVERE MENTAL ILLNESS AND SERIOUS EMOTIONAL DISTURBANCES OF CHILDREN EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[SIGMOIDOSCOPIC EXPENSE BENEFIT

Covered Percentage:	{100%} of actual Expense
Benefit Maximum:	{$3,000}]

[TEMPOROMANDIBULAR JOINT / CRANIOMANDIBULAR DISORDER EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
Benefit Maximum:	{$3,000} lifetime maximum]

[TREATMENT OF MORBID OBESITY EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of [R & C]
Benefit Maximum:	{$3,000} lifetime maximum]

[CLINICAL TRIALS FOR PREVENTION, EARLY DETECTION AND TREATMENT OF CANCER EXPENSE BENEFIT

Covered Percentage:	{80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]
Benefit Maximum:	{$3,000}]

[ANNUAL ROUTINE EXAM EXPENSE BENEFIT

Covered Percentage:	{100%} of actual Expense
Benefit Maximum:	{$150}]

[BREAST IMPLANT REMOVAL EXPENSE BENEFIT

Covered Percentage:	**{**80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

INFERTILITY EXPENSE BENEFIT

Covered Percentage:	**{**80-100%} of R & C [up to the first {0-$5,00} then {0-90%} of R & C]

[MASTECTOMY EXPENSE BENEFIT

Covered Percentage:	**{**80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[PEDIATRIC PREVENTIVE CARE EXPENSE BENEFIT
Covered Percentage: {80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[POST-MASTECTOMY EXPENSE BENEFIT
Covered Percentage: {80-100%} of R & C [up to the first {0-$5,00} then {0-90} of R & C]

[PROSTATE-SPECIFIC ANTIGEN EXPENSE BENEFIT
Covered Percentage: {80-100%} of R & C [up to the first {0-$5,000} then{0-90%} of R & C]

[CANCER CLINICAL TRIAL EXPENSE BENEFIT
Covered Percentage: {80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[DAY SURGERY MISCELLANEOUS EXPENSE BENEFIT
Covered Percentage: {80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

[TELEMEDICINE MEDICAL SERVICE BENEFIT
Covered Percentage: {80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

PHENYLKETONURIA EXPENSE BENEFIT
Covered Percentage: {80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

PREVENTIVE CARE FOR DEPENDENT CHILDREN EXPENSE BENEFIT
Covered Percentage: {80-100%} of R & C [up to the first {0-$5,000} then {0-90%} of R & C]

SCHEDULE OF PREMIUM RATES

CLASS OF INSURED PERSONS	TERM OF COVERAGE	PREMIUM RATE
[Student Only	Annual	$
Spouse Only	Annual	$
Child(ren) Only	Annual	$
Student Only	Fall	$
Spouse Only	Fall	$
Child(ren) Only	Fall	$
Student Only	Spring	$

Spouse Only	Spring	$
Child(ren) Only	Spring	$
Student Only	Summer	$
Spouse Only	Summer	$
Child(ren) Only	Summer	$

GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

Accident means a specific unforeseen event which happens while the Insured Person is covered under this Policy and which, directly and from no other cause, results in an Injury.

[Allowed Application Period means a period of [15] days after the Policy Effective Date or for those students who start mid year, [15] days from the start of the [quarter] during which an eligible student may enroll and be covered as of the Policy Effective Date or the start of the [quarter], respectively.]

Application means any enrollment form required by the Policyholder for coverage under this Policy.

[Benefit Period means the [12 months**]** immediately following the date of the Accident or first treatment of a Sickness.**]**

Coinsurance means the percentage of Reasonable and Customary Expenses for which the Insured Person is responsible for a covered service.

Complications of Pregnancy means conditions which require Hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:

- acute nephritis or nephrosis; and
- cardiac decompensation or missed abortion; and
- similar medical and surgical conditions of comparable severity; and
- non-elective caesarean section; and
- termination of an ectopic pregnancy; and
- spontaneous termination when a live birth is not possible. (This does not include elective abortion.)

Not included are: (a) false labor, occasional spotting or doctor prescribed rest during the period of pregnancy; (b) morning sickness; (c) hyperemesis gravidarum and preeclampsia; and (d) similar conditions not medically distinct from a difficult pregnancy.

Copayment means the specified dollar amount an Insured Person must pay for specified charges. The copayment is separate from and not a part of the Deductible or Coinsurance.

Covered Charge or Covered Expense as used herein means those charges for any treatment, services or supplies that are: (a) for Network Providers, not in excess of the Preferred Allowance; (b) for Non-Network Providers, not in excess of the Reasonable and Customary Expenses; (c) not in excess of the charges that would have been made in the absence of this insurance; and (d) incurred while this Policy is in force as to the Insured Person except with respect to any expense payable under the Extension of Benefits Provision.

Covered Percentage means that part of the Covered Charge that is payable by the Company after the Deductible or Copayment has been met.

[Deductible means the amount of Expenses for covered services and supplies which must be incurred by the Insured Person before specified benefits become payable**.**]

[Dependent means: (a) the Insured Student's spouse **[**residing with the Insured Student] [or Domestic Partner residing with the Insured Student]; or (b) the Insured Student's unmarried children under the age of 25. Children must be fully supported by the Insured Student. Coverage for newborn children will consist of coverage for Sickness or Accident, including routine newborn care and the necessary care or treatment of congenital defects, birth abnormalities, or premature birth. Such coverage will start from the moment of birth, if the Insured Student is already insured for dependent coverage when the child is born. If the Insured Student does not have dependent coverage when the child is born, We cover the newborn child for dependent benefits from and

after the moment of birth. To continue the newborn child's dependent benefits past the first 90 days, the Insured Student must notify Us in writing within 90 days of the child's birth.

If payment of a specific premium is required to provide coverage for a child, such premium must be paid within 90 days after the date of birth in order to have the coverage continue beyond such 90 day period. If an application or other form of enrollment is required in order to continue coverage beyond the 90 period after the date of birth and the Student has notified Us of the birth within such 90 day period, We will, upon notification, provide the Student with all forms and instructions necessary to enroll the newly born child and We will allow the Student an additional ten days from the date the forms and instructions are provided in which to enroll the newly born child.

The term children includes an Insured Student's biological children and step-children who depend on the Insured Student for their full support.

Adopted children of the Insured Student are covered on the same basis as other Dependent children: (a) from the date of birth if a petition for adoption is filed within 60 days of the birth of such child; or (b) from the date of Placement for the purpose of adoption if a petition for adoption is filed within 60 days of Placement of such child. Such coverage shall continue unless the Placement is disrupted prior to legal adoption and the child is removed from Placement. Coverage shall include the necessary care and treatment of medical conditions existing prior to the date of Placement. As used here, Placement means in the physical custody of the adoptive Insured Student.

A child's coverage will not end because the child has reached the age limit shown above, if he or she: (a) is not able to earn his or her own living as a result of mental or physical handicap; and (b) became so handicapped before reaching the age limit; and (c) is chiefly dependent on the Insured Student for support and maintenance.

The Insured Student must send us proof of the child's dependency or handicap whenever requested. This will be at Our Expense. If the incapacity or dependency is thereafter removed or terminated. You must notify us.

[Any Dependent on active duty in any military, naval, or air force of any country is not eligible for coverage under this Policy.]]

Doctor as used herein means: (a) a legally qualified physician licensed by the state in which he or she practices; or (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of residence of such practitioner; or (c) a certified nurse midwife while acting within the scope of that certification.

[Domestic Partner means the same sex partner of an Insured Student who has filed a "Declaration of Domestic Partnership" with the Policyholder's administrative offices and who: (a) has been residing with the Insured Student for at least 12 consecutive months, and intends to do so indefinitely; (b) is considered the Insured Student's "sole Domestic Partner"; (c) is, along with the Insured Student, at least 18 years of age; (d) is, along with the Insured Student, jointly responsible for each other's welfare and financial obligations; and (e) is, along with the Insured Student, not married or related by blood.**]**

[Domestic Student is a student classified as a United States Citizen or eligible Non-Citizen (Permanent Resident or Refugee).**]**

Effective Date means the first date a student becomes covered under the Policy.

Elective Treatment means medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Insured Person's Effective Date of coverage.

Elective Treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction; breast implants; sexual reassignment surgery; impotence (organic or otherwise); submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered chronic purulent sinusitis; treatment for weight reduction; learning disabilities; immunizations; treatment of infertility and routine physical examinations.**]**

[Experimental or Investigational Care means a service or supply:
(a) that We, in Our discretion, determine is not commonly and customarily recognized as being safe and effective for the particular diagnosis or treatment; or
(b) which requires approval by any governmental authority and such approval has not been granted before the service or supply is furnished.

We may rely upon the advice of medical consultants and commonly recognized national medical organizations in determining which services or supplies are experimental or investigational.**]**

Hospital means a facility which meets all of these tests:
(a) it provides inpatient services for the care and treatment of injured and sick people; and
(b) it provides room and board services and nursing services 24 hours a day; and
(c) it has established facilities for diagnosis and surgery; and
(d) it is supervised by a Doctor; and
(e) it is run as a Hospital under the laws of the jurisdiction in which it is located.

Hospital does not include a place run mainly: (a) for alcoholics or drug addicts; (b) as a convalescent home; (c) as a nursing or rest home; or (d) as a hospice facility.

Hospital Confinement means a stay of 18 or more consecutive hours as a resident bed-patient in a Hospital.

Injury means bodily injury caused by an Accident which is the sole cause of the Loss. All injuries due to the same or a related cause are considered one Injury.

Insured Person means an Insured Student **[**and his or her covered Dependent(s)**]** while insured under this Policy.

Insured Student means a student of the Policyholder who is eligible and insured for coverage under this Policy.

[International Student is a student classified as a Non-Immigrant. For example, students holding visa types: "F" (Student), "J" (Exchange Visitor), "B" (Tourist), or "A" (Diplomat).**]**

[Lifetime Aggregate Maximum means the total amount of benefits payable for all Injuries and Sicknesses combined under this Student Health Insurance Policy or Policies issued to the Policyholder with respect to the Policyholder immediately before this Policy.**]**

Loss means medical expense covered by this Policy as a result of Injury or Sickness as defined in this Policy, and other expenses as specifically covered.

Medical Emergency means the sudden and, at the time, unexpected onset of an Injury [or Sickness] that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but is not limited to:

(a) placing the person's health in significant jeopardy;
(b) serious impairment to a bodily function;
(c) serious dysfunction of any bodily organ or part;
(d) inadequately controlled pain; or
(e) with respect to a pregnant woman if she is having contractions:
    1. that there is inadequate time to effect to safe transfer to another Hospital before delivery; or
    2. that transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

Medically Necessary means that a service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice. A service or supply will not be considered as Medically Necessary if:
(a) it is provided only as a convenience to the Insured Person or provider;
(b) it is not the appropriate treatment for the Insured Person's diagnosis or symptoms;

(c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

The fact that any particular Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

[Network Providers are Doctors, Hospitals and other healthcare providers who have contracted to provide specific medical care at negotiated prices.**]**

[Non-Network Providers have not agreed to any pre-arranged fee schedules.**]**

[Out-of-Pocket Maximum means the maximum dollar amount an Insured Person is responsible to pay during a Policy Year. After an Insured Person has reached the Out-of-Pocket Maximum, We cover most benefits at 100% for the remainder of the Policy Year. Some benefits, however, will always remain payable at the percentage shown in the Plan of Insurance. The Out-of-Pocket Maximum is met by accumulated Deductible [and] Coinsurance [and Copayments *or* Co-payments are not applied to the Out-of-Pocket maximum.]. Penalties and amounts above the Reasonable and Customary Expense do not count toward the Out-of-Pocket Maximum. The Out-of-Pocket Maximum is shown in the Plan of Insurance.**]**

[Per Condition Aggregate Maximum means the total amount of benefits payable for each Injury or Sickness under this Student Health Insurance Policy or Policies issued to the Policyholder with respect to the Policyholder immediately before this Policy.**]**

Policy Effective Date means the date the Policy takes effect as shown in the Plan of Insurance.

[Policy Termination Date means the last day of the policy term shown on the first page of the policy.**]**

Policyholder means the institution indicated on the face page of this Policy.

Policy Year means the 12 month period beginning on the Policy Effective Date.

Pre-Existing Condition means any injury sustained in an accident that occurred, or a sickness that first manifested itself, before the Insured Person's effective date of coverage under this Policy and for which the Insured Person has not received any diagnosis, medical advice, care or treatment within the 6-month period immediately preceding his effective date of coverage. A pregnancy that existed on an Insured Person's effective date will not be considered Pre-Existing Condition.

Benefits for a Pre-Existing Condition may be limited. Please read the *General Exclusions and Limitations* section for any applicable limitations.

[Preferred Allowance means the amount a Network Provider will accept as payment in full for Covered Charges.**]**

Reasonable and Customary Expenses means fees and prices generally charged within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.

Sickness means sickness or disease which is the sole cause of the Loss. Sickness includes both normal pregnancy and Complications of Pregnancy. All sicknesses due to the same or a related cause are considered one Sickness.

We, Us and **Our** mean QBE Insurance Corporation, domiciled in Pennsylvania.

You and **Your** mean the Insured Person.

EFFECTIVE DATE, POLICY TERM, POLICY TERMINATION & RENEWAL

This Policy takes effect as of the Policy Effective Date stated in the Plan of Insurance. It continues in force until the Policy Termination Date. Subject to Our consent, this Policy may be renewed for like periods by the payment, within the Grace Period provided in the General Provisions Section, of the renewal premium at the premium rate then in force. We reserve the right to adjust the premium rate on the first anniversary of the Policy Effective Date. We will give the Policyholder at least {60} days prior written notice. We also reserve the right to refuse to renew this Policy.

However, in no event will We refuse to renew or cancel this Policy during any term for which premium has been paid.

EFFECTIVE DATE AND TERMINATION DATE OF INDIVIDUAL COVERAGE

EFFECTIVE DATE OF INSURED PERSON'S COVERAGE

The insurance of each Eligible Student shall take effect as follows:

[[(a) If an Eligible Student enrolls and pays any required premium on or before the Policy Effective Date, coverage will begin on the Policy Effective date;]
[(b) If an Eligible Student enrolls and pays any required premium after the Policy Effective Date but within the Allowed Application Period, coverage will begin on the Policy Effective Date or the start of the term or semester in which the student has enrolled;]
[(c) If an Eligible Student enrolls and pays any required premium] after the Allowed Application Period, coverage will begin on the day after the enrollment card and premium is received; or]
[(d) If an Eligible Student enrolls and pays any required premium on or before the Policy Effective Date and such student is a participant in intercollegiate sports or a school sponsored activity or requirement, coverage will begin on the date the eligible student is required to be on campus.]]

LATE ENROLLMENT FOR DEPENDENTS

An Eligible Student may add his or her Dependent as a late enrollee:
[(a) when he or she marries. The application for coverage must be submitted within 31 days of the date of marriage. Coverage will be effective on the date of the marriage. Payment for the full semester or pro-rated premium for the remainder of the semester, is required even if the spouse is enrolled after the term has begun;]
[(b) when he or she provides a signed affidavit of Domestic Partnership. Proof of Domestic Partnership may be required. Payment for the full semester or pro-rated premium for the remainder of the semester, is required even if the Domestic Partner is enrolled after the term has begun;]
[(c) when he or she acquires a Dependent child through birth, adoption or guardianship decree. The application must be submitted within 31 days of the date the child is born, adopted or acquired through decree. Coverage will be effective as of the date of birth, adoption or guardianship. Payment for the full semester or pro-rated premium for the remainder of the semester, is required even if the Dependent child is enrolled after the term has begun; and]
[(d) when his or her Dependent arrives from a foreign homeland. The application for coverage must be submitted within 31 days of the date of the Dependent's arrival from the foreign homeland. Coverage will be effective as of the date of the Dependent's arrival following direct travel from the homeland. Payment for the full semester or pro-rated premium for the remainder of the semester, is required even if the Dependent is enrolled after the term has begun.;]

[If the Eligible Student does not add a new Dependent within 31 days of the date the Dependent becomes eligible for coverage, he or she must wait until the following school term to add the Dependent for coverage.]

TERMINATION DATE OF INSURED PERSON'S COVERAGE

The insurance for an Insured Person shall terminate on the first of the following dates:
[[(a) on the date this Policy is terminated;] or
[(b) on the premium due date if the required premium for the Insured Person is not paid, except as a result of inadvertent error;] or

[(c) as of the date the Insured Person enters military service, in which case a pro-rata refund of premium will be made to such Insured Person;] or

[(d) on the date the Insured Person no longer qualifies under the Description of Class as shown in the Schedule of Eligible Classes;] or

[(e) on the last day the Insured Student is required to be on campus at the Policyholder or, if the Policyholder has so elected, the anniversary of the Policyholder's Policy.]]

Termination of Insurance for an Insured Person shall be without prejudice to any claim which starts prior thereto.

[If a student loses eligibility under this Policy because he or she no longer qualifies under the terms described in the Master Policy, he or she may apply for continuation of coverage. The application must be made within 31 days of losing eligibility, and the applicable premium must be paid.]

RENEWABILITY OF COVERAGE

A student who is enrolled as a regular undergraduate or graduate student at the College or University will be provided with continuous coverage under this Policy for himself or herself and his or her Insured Dependents each subsequent year the Policyholder renews this Policy with Us. Once an Insured Person has been covered under this Policy and satisfied any Pre-existing Condition Limitation exclusion period, if applicable, coverage under this Policy will be considered continuous. The student must apply for coverage and pay premiums as described in the Policy.

CONTINUOUS INSURANCE AND EXTENSION OF BENEFITS PROVISIONS

Continuous Insurance This Policy may be replacing a Prior Plan with another insurer.

Prior Plan means the Student Health Insurance policy or policies issued to the Policyholder with respect to the Policyholder immediately before the current Policy.

Injury or **Sickness** shall include an Injury sustained, or a Sickness first manifesting itself, while the Insured Person is continuously insured under the Prior Plan and became insured under this Policy without a break in coverage.

But no benefits shall be payable for such Injury or Sickness to the extent that such benefits are payable under the Prior Plan for the same expenses. This will apply even though the Prior Plan provided that it will not duplicate the benefits under another Policy.

Also, the total amount of benefits payable for Injury or Sickness under this Policy and the Prior Plan cannot exceed the [Lifetime Aggregate Maximum] [or the Per Condition Aggregate Maximum].

Nothing contained herein shall be held to vary, alter, waive, or extend any of the provisions, exclusions, and other terms of this Policy, except as provided above.]

Extension of Benefits

If an Insured Person is confined to a Hospital on the date his or her insurance terminates, charges incurred during the continuation of that Hospital Confinement shall also be included in the term Expense, but only up to the limit of liability otherwise imposed under the Policy for the sickness or injury causing the hospital confinement.

[MANAGED CARE PROVISIONS *This section will appear if a Policyholder elects a the PPO Plan*

This Policy provides benefits based on the type of health care provider the Insured Person or his or her Dependent selects. This Policy provides access to both Network Providers and worldwide coverage for Non-Network Providers.

This Policy will pay the Covered Percentage of the Preferred Allowance for Covered Charges if the Insured Person or his or her Dependent uses a Network Provider. This Policy will pay the Covered Percentage of the Reasonable and Customary Expense for Covered Charges if a Non-Network Provider is used. All payments will be subject to any applicable Deductible, Coinsurance, Maximum Benefits, and other provisions or limitations in this Policy. Eligible Expenses are payable in accordance with the "Section I: Plan of Insurance". The [Lifetime Aggregate Maximum] [or Per Condition Aggregate Maximum] for all Covered Charges is {$500,000} per Insured Person.

Use of Network Providers offers better benefits for the Insured Person. Non-Network Provider services are subject to the Deductible and higher Coinsurance. Refer to the Plan of Insurance for a complete description of coverage.

The Insured Person should be aware that Network Provider Hospitals may be staffed with Non-Network Providers. Receiving services from a Network Provider does not guarantee that all charges will be paid at the Network Provider level of benefits.

It is important that the Insured Person verify that his or her Doctors are Network Providers each time he or she calls for an appointment or at the time of service.

[DEDUCTIBLE, COINSURANCE AND COPAYMENT RULES

[DEDUCTIBLE The Insured Person's Deductible applies to all **[**Network and**]** Non-Network Provider Covered Charges unless specified otherwise in this Policy.]

[Deductible Carry Over - Any eligible expenses incurred during the last {three 3}) months of the benefit period and credited to the Deductible for that Policy Year will be applied toward the next year's Deductible.]

[Common Accident - If two or more family members are hurt in the same Accident, only one Deductible needs to be satisfied among them for Expenses relating to the Accident. This special feature applies to eligible Expenses each Policy Year for the same Accident**.]**

[COINSURANCE/COPAYMENTS Some covered services are subject to Coinsurance and Copayments. This is the amount the Insured Person must pay to the Doctor or Hospital for each procedure, visit or confinement each time he or she receives a covered service, including prescription drugs. The Coinsurance is not applied until after the Insured Person has paid any applicable Deductible that may be required under this Policy. What We pay is shown in the Plan of Insurance. The Coinsurance and Copayments, whether from a Network or a Non-Network Provider, apply toward the Out-of-Pocket Maximum.

Covered services which are rendered by a Network Provider and subject to a Copayment will not be subject to the Deductible.]]

[OUT OF POCKET MAXIMUM The Out-of-Pocket Maximum applies to covered services rendered by a Network Provider and Non-Network Provider. Once the Insured Person reaches the Out-of-Pocket Maximum shown in the Plan of Insurance, eligible Expenses will be paid at 100% of Covered Charges for the remainder of the Policy Year or until he or she reaches the [Lifetime Aggregate Maximum] [or Per Condition Aggregate Maximum] as outlined in the Plan of Insurance, whichever occurs first. The Out-of-Pocket Maximum is met by accumulated [Deductible], [Coinsurance] and [Copayments].]

[WAIVER OF COPAYMENT The Emergency Room Copayment will be waived if the Insured Person is admitted to the Hospital immediately following emergency room treatment. The admission must be for the same condition for which the Insured Person received Medical Emergency care**.]]**

ACCIDENT AND SICKNESS COVERAGE PROVISIONS

All benefits to this Policy are shown in the Plan of Insurance. The benefits are described on the pages attached to and made a part of this Policy.

[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

We will pay the benefit for any one of the Covered Losses listed in the *Schedule of Benefits,* if a Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident within the applicable time period specified in the *Schedule of Benefits.*

Loss of hands and feet means the loss at or above the wrist or ankle joints. Loss of eyes means total irrecoverable loss of the entire sight. **[**Loss with regards to thumb and index finger means severance through or above metacarpophalangeal joints.**]**

Only one of the amounts named above will be paid for Injuries resulting from any one Accident. The amount so paid shall be the largest amount that applies.

This provision does not cover the Loss if it in any way results from or is caused or contributed:

(1) By physical or mental illness; medical or surgical treatment except treatment that results directly from a surgical operation made necessary solely by an Injury covered by the Policy;

(2) By an infection, unless it is caused solely and independently by a covered Accident or if it is a bacterial infection resulting from the accidental ingestion of contaminated substances;

(3) **[**For Expenses for which a contributing cause was the Insured Person's commission of, or attempt to commit a felony, or for which an Insured Person's engagement in an illegal occupation was the contributing cause; or**]**

(4) **[**While the Insured Person is legally intoxicated or under the influence of any drug unless taken as prescribed by a Doctor.**]**

In addition to the above, this provision is subject to the Exclusions as provided.**]**

ACCIDENT EXPENSE BENEFIT

When, by reason of Injury, an Insured Person incurs expenses for hospital, surgical or medical treatment, services or supplies, We will pay the Covered Percentage of the Covered Charges incurred [within 52 weeks from the date of Accident] as shown in the Plan of Insurance. Benefits are paid in accordance with the schedule shown for the Accident Expense Benefits in the Plan of Insurance. When an Insured Person incurs expenses for dental treatment for Injury to sound natural teeth, We will pay for the Covered Percentage of the Covered Charges incurred [within 52 weeks of the date of the Accident], as shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.

[SICKNESS EXPENSE BENEFIT *program may be offered on accident only or accident and sickness basis. Deleted when accident only*

When, by reason of Sickness, an Insured Person incurs expenses for hospital, surgical or medical treatment, services or supplies, We will pay for the Covered Percentage of the Covered Charges covered by the Sickness Expense Benefit Provisions incurred [within 52 weeks from the date of the first medical treatment for the Sickness] as shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.

Charges that are not covered for Accident & Sickness Expense Benefits

Charges to buy or rent:

- Air conditioners;

- Air purifiers;
- Motorized transportation equipment;
- Escalators or elevators in private homes;
- Eye glass frames or lenses, hearing aids;
- Swimming pools or supplies for them;
- General exercise equipment.]

HOSPITAL EXPENSE BENEFIT

Part A **Hospital Room and Board Expense**

When, by reason of Injury or Sickness, an Insured Person requires Hospital Confinement, We will pay the Covered Percentage of the Hospital room and board Covered Charge for a semi-private room containing two or more beds including meals, special diets and nursing services incurred for the period of such Hospital Confinement. Coverage includes a bed in a newborn nursery, special care, or intensive care unit.

Part B **Miscellaneous Hospital Expense**

[Miscellaneous Hospital Expense includes expenses incurred for:

(a) anesthesia, anesthesia supplies and services;
(b) operating, delivery and treatment rooms and equipment;
(c) diagnostic x-ray and laboratory tests;
(d) lab studies;
(e) oxygen tent;
(f) blood and blood services;
(g) prescribed drugs and medicines;
(h) medical and surgical dressings, supplies, casts and splints;
(i) radiation therapy, intravenous chemotherapy, kidney dialysis, and inhalation therapy;
(j) chemotherapy treatment with radioactive substances;
(k) intravenous injections and solutions, and their administration;
(l) physical and occupational therapy; and
(m) other necessary and prescribed Hospital expenses.**]**

We will pay the Covered Percentage of the Covered Charge incurred by the Insured Person during the period of Hospital Confinement or for a Surgical Procedure performed on an outpatient basis.

What We pay is shown in the Plan of Insurance.

SURGICAL EXPENSE BENEFIT

Part A **Surgery Expense Benefit**

When, by reason of Injury or Sickness, an Insured Person requires surgery on an inpatient or outpatient basis, We will pay the Covered Percentage of the Covered Charges of the Surgical Expense, in connection with any one Surgical Procedure, subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.

Definitions

Surgical Expense means charges by a Doctor for:
(a) a Surgical Procedure;
(b) necessary preoperative treatment during a Hospital stay in connection with such procedure; and
(c) usual post-operative treatment.

Surgical Procedure means:
(a) a cutting procedure;
(b) suturing of a wound;

(c) treatment of a fracture;
(d) reduction of a dislocation;
(e) radiotherapy;
(f) electrocauterization;
(g) diagnostic and therapeutic endoscopic procedures;
(h) injection treatment for hemorrhoids and varicose veins;
(i) an operation by means of a laser beam.

Part B Multiple Surgical Procedures Expense Benefit

When Injury or Sickness requires multiple Surgical Procedures through the same incision, We will pay an amount not less than that for the most expensive procedure being performed. Multiple Surgical Procedures performed during the same operative session but through different incisions shall be reimbursed in an amount not less than the Covered Percentage of the Covered Charge of the most expensive Surgical Procedure then being performed[, and with regard to the less expensive Surgical Procedure in an amount equal to [50] percent of the Covered Percentage of the Covered Charge for these procedures].

[Part C Anesthesia Expense Benefit

If, in connection with such operation, the Insured Person requires the services of an anesthetist, We will pay the Expenses incurred; but We will not pay more than the Covered Percentage of the Covered Charges subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.]

[Part D Assistant Surgeon Expense Benefit

If, in connection with such operation, the Insured Person requires the services of an Assistant Surgeon, We will pay the Expense incurred; but We will not pay more than the Covered Percentage of the Covered Charges subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.]

[Part E Second Surgical Opinion Expense Benefit

We will also provide benefits to an Insured Person for a second opinion consultation by a board certified specialist on the need for non-emergency surgery which has been recommended by the Insured Person's Doctor. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Benefits will also be provided for any required x-rays and diagnostic tests done in connection with that consultation.

We will pay the Covered Charges incurred by the Insured Person as shown in the Plan of Insurance. [Any Deductible or Coinsurance is waived for Expenses incurred in connection with the Second Surgical Opinion.]

What We pay is shown in the Plan of Insurance.]

IN-HOSPITAL DOCTOR'S FEES AND MEDICAL EXPENSE BENEFIT

When, by reason of Injury or Sickness an Insured Person who is confined as a resident bed-patient in a Hospital, requires the services of a Doctor, who may or may not have performed the surgery on the Insured Person, We will pay the Covered Percentage of the Covered Charge incurred for such services, subject to the Deductible shown in the Plan of Insurance.

[The following medical services performed by a Doctor are covered on an inpatient basis:
[(a) one Doctor visit per day;]
[(b) constant care and treatment while an Insured Person is confined in an intensive care unit;]
[(c) care by two or more Doctors during one Hospital stay when the Insured Person's condition requires the skill of separate Doctors;]

[(d) consultation by another Doctor when requested by the Insured Person's Doctor. Coverage is limited to one consultation per admission. Staff consultations required by Hospital rules are not covered.]]

What We pay is shown in the Plan of Insurance.

OUTPATIENT EXPENSE BENEFIT

If, by reason of Injury or Sickness, an Insured Person incurs expenses in a Doctor's office, Hospital outpatient department, emergency room, clinical lab, radiological facility, or other similar facility licensed by the state, We will pay the Covered Percentage of the Covered Charges incurred as shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.

Outpatient Services

[Covered Charges for Outpatient Services include the following services:
(a) a Doctor's office while not Hospital Confined;
(b) chiropractic care up to the maximum shown in the Plan of Insurance;
(c) a Hospital outpatient department or emergency room;
(d) diagnostic x-ray and laboratory testing;
(e) blood and blood services, if provided and billed by a Hospital or other facility;
(f) physical and occupational therapy as shown in the Plan of Insurance;
(g) radiation therapy, intravenous chemotherapy, kidney dialysis, inhalation therapy;
(h) radiological lab or other similar facility licensed by the state;
(i) surgical dressings, splints, casts, and other devices used to correct fractures and dislocations;
(j) speech therapy by a licensed speech therapist to restore speech loss or correct speech impairment after corrective surgery, or following an Injury for Sickness other than a mental or learning disorder. Speech therapy must be in keeping with a Doctor's written order for type, frequency, and duration;
(k) shots and injections when received in the Doctor's office;
(l) immunizations [at the Student Health Center];
(m) acupuncture [up to the maximum shown in the Plan of Insurance.]
(n) allergy testing and/or treatment.]

If the Outpatient Services are in connection with surgery and the Doctor is the surgeon who performed or is to perform the surgery, no benefits are payable under this provision. All surgery charges are paid under the Surgical Expense Benefits provision.

[High Cost Procedures
High Cost Procedures, as used herein, means an outpatient procedure costing over {$200}..
Covered charges for High Cost Procedures include, but not limited to, charges for the following procedures and services.

(1) C.A.T. Scan;
(2) Magnetic resonance imaging; and
(3) Laser treatment.

The maximum benefit for High Cost Procedures is shown in the Plan of Insurance. If, by reason of similar benefit provision elsewhere contained, this Policy provides for reimbursement for the same charges, no benefits shall be payable under those provisions. These benefits are in place of all other benefits of this Policy.]

[**MATERNITY EXPENSE BENEFIT** *program may be offered on accident only or accident and sickness basis. Deleted if accident only, included if mandated for sickness*

We will pay benefits for an Insured Person's Covered Charges for maternity care, including Hospital, surgical and medical care.

We cover charges for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of inpatient care following an uncomplicated cesarean section for a mother and her newborn child in a health care facility, unless the attending Doctor, in consultation with the mother, makes a decision for an earlier discharge from the Hospital. The Doctor's approval to discharge must be made in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization.

For a mother and newborn child who remain in the Hospital for the minimum length of time stated above, We will pay for one home health care visit if prescribed by the attending Doctor.

For a mother and newborn child who have a shorter Hospital stay, We will pay for post-discharge care to the mother and her newborn. Post-discharge care will consist of two visits by a Doctor or a registered professional nurse with experience in maternal and child health nursing. The location and schedule of the visits will be determined by the Doctor. One visit must be in the Insured Person's home. Services may be provided in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or other nationally recognized medical organization.

Newborn Infant Care – Newborn infant care is covered when the infant is confined in the Hospital and has received continuous Hospital care from the moment of birth. [This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures.] [This benefit does not include circumcision.] This benefit also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children covered from birth.

Covered services may be provided by a certified nurse-midwife under qualified medical direction if he or she is affiliated with or practicing in conjunction with a licensed facility.

We cover such charges the same way We treat Covered Charges for any other Sickness. What We pay is shown in the Plan of Insurance.]

[**OPTIONAL MAMMOGRAPHIC EXAMINATION EXPENSE BENEFIT,** *program may be offered on accident only or accident and sickness basis. Deleted if accident only, included if mandated for sickness*

We will pay the Covered Percentage of the Covered Charges incurred for mammographic exams. The charges must be incurred while the Insured Person is insured for these benefits.

Benefits will be paid for mammographic exam charges incurred for the following:

(a) One baseline Mammogram for a woman 35 through 39 years of age;
(b) One Mammogram every 24 months for a woman forty through 49 years of age, inclusive, or more frequently upon recommendation of a Doctor;
(c) One Mammogram every12 months for a woman 50 years of age or older;
(d) A Mammogram for any woman, upon the recommendation of a Doctor, where such woman, her mother or her sister has a prior history of breast cancer.

We cover such charges the same way We treat Covered Charges for any other Sickness. What We pay is shown in the Plan of Insurance.

Definition: Mammogram means an X-ray examination of the breast using dedicated equipment, including X-ray tube, filter, compression device, screens, films and cassettes specifically for mammography that delivers an average radiation exposure of less than one rad mid-breast with two views for each breast. The term includes the professional interpretation of the film.]

[PELVIC, CERVICAL, PROSTATE AND COLORECTAL EXAM EXPENSE BENEFIT *program may be offered on accident only or accident and sickness basis. Deleted if accident only, included if mandated for sickness*

We will cover the Covered Percentage of Covered Charges for Expenses incurred for all of the following examinations:

(a) an annual pelvic examination and pap smear for any non-symptomatic female Insured Person; and
(b) an annual prostate examination and laboratory tests for any non-symptomatic male Insured Person; and

(c) an annual colorectal cancer examination and laboratory tests for any non-symptomatic Insured Person.

All examinations and laboratory tests must be performed in accordance with the current guidelines established by the American Cancer Society.

We cover such charges the same way We treat Covered Charges for any other Sickness. What We pay is shown in the Plan of Insurance.]

[ABORTION EXPENSE BENEFIT

If as a result of pregnancy an Insured Person has an Elective Abortion, We will pay the Covered Percentage of the Covered Charges incurred subject to the Deductible shown in the Plan of Insurance. Expenses for the Elective Abortion must be incurred while the Policy is in force as to the Insured Person.

Definition

Elective Abortion means an abortion for any reason other than a spontaneous abortion or to prevent the death of the female upon whom the abortion is performed

What We pay is shown in the Plan of Insurance.]

[ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) VACCINE EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for a vaccine for AIDS. Such vaccine must be:
approved for marketing by the federal Food and Drug Administration; and
recommended by the United States Public Health Service.

Provision of this benefit does not include coverage for any clinical trials relating to an AIDS vaccine or for any AIDS vaccine that has been approved by the federal Food and Drug Administration in the form of an investigational new drug application.

The policy exclusion for vaccines is amended to read as follows: Preventative medicines, serums or vaccines of any kind, excluding an AIDS vaccine as mandated by applicable law.

What We pay is shown in the Plan of Insurance.]

[AMBULANCE EXPENSE BENEFIT

When, by reason of Injury or Sickness, an Insured Person requires the use of a community or Hospital ambulance in a Medical Emergency, We will pay the Covered Percentage of the Covered Charges incurred as shown in the Plan of Insurance.

Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, scene of accident or Medical Emergency to a Hospital or between Hospitals.

Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area. Air transportation is covered when Medically Necessary because of a life threatening Injury or Sickness. Air ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for inpatient care.

What We pay is shown in the Plan of Insurance.]

[CONSULTANT EXPENSE BENEFIT

If by reason of Injury or Sickness, an Insured Person requires the services of a Consultant or Specialist when they are deemed necessary and ordered by an attending Doctor for the purpose of confirming or determining a diagnosis, We will pay the Covered Percentage of the Covered Charges incurred.

What We pay is shown in the Plan of Insurance.]

[DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

If, by reason of Injury or Sickness, an Insured Person requires the use of Durable Medical Equipment, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for such Durable Medical Equipment, subject to the Deductible shown in the Plan of Insurance. We pay the Covered Percentage of the Covered Charges incurred by the Insured Person for the purchase of such Durable Medical Equipment when the purchase price is expected to be less costly than rental. If Durable Medical Equipment is purchased it is our property and is to be returned to Us, at Our expense, upon completion of the Insured Person's need, if so requested by Us.

We do not pay for the replacement of Durable Medical Equipment.

What We pay is shown in the Plan of Insurance.

Definition

Durable Medical Equipment means medical equipment that: 1) is prescribed by the Doctor who documents the necessity for the item including the expected duration of its use; 2) can withstand long term repeated use without replacement; 3) is not useful in the absence of an Injury or Sickness; and 4) can be used in the home without medical supervision.]

[HOME HEALTH CARE EXPENSE BENEFIT *included if mandated by state*

We will cover charges for Home Health Care services furnished to an Insured Person. Such benefits must be provided by a licensed Home Health Agency.

We will pay for Covered Charges up to a maximum of {100 visits} in any calendar year or in any continuous period of 12 months. Covered Charges are subject to {80%} of the Reasonable and Customary Expense. Except for a home health aide, each visit by a representative of a Home Health Agency shall be considered as one home health visit. A visit of four (4) hours or less by a home health aide, shall be considered as one home health visit.

Charges for such services are not subject to the Deductible.

What We pay in shown in the Plan of Insurance.

Definitions

Home Health Care means the continued care and treatment of an Insured Person who is under the direct care and supervision of a Doctor but only if: (a) continued hospitalization would have been required if Home Health Care were not provided; (b) the home health treatment plan is established and approved by a Doctor within 14 days after an inpatient Hospital Confinement has ended and such treatment plan is for the same related condition for which the Insured Person was hospitalized; and (c) Home Health Care commences within 14 days after the Hospital Confinement has ended.

Home Health Services Consist of, but shall not be limited to, the following: (a) part-time or intermittent skilled nursing services provided by a registered nurse or licensed vocational nurse; (b) part-time or intermittent home health aide services which provide supportive services in the home under the supervision of a registered nurse or a physical, speech or occupational therapist; (c) physical, occupational or speech therapy; and (d) medical supplies, drugs and medicines prescribed by a Doctor and related pharmaceutical services, and laboratory services to the extent such charges or costs would have been covered under the Policy if the Insured Person had remained in the Hospital.

Home Health Agency means a public or private agency or organization licensed by the State Department of Health Services in accordance with the provisions of the Health and Safety Code.]

[LARYNGECTOMY EXPENSE BENEFIT

We pay benefits for charges for Prosthetic Devices to restore a method of speaking for the Insured Person incident to a Laryngectomy.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

Definitions:
Laryngectomy means the removal of the larynx for Medically Necessary reasons, as determined by a licensed Doctor and surgeon.

Prosthetic Devices means and includes the provision of initial and subsequent Prosthetic Devices, including installation accessories, pursuant to an order of the patient's Doctor and surgeon. Prosthetic Devices does not include electronic voice producing machines.]

[LICENSED NURSE EXPENSE BENEFIT

If by reason of Injury or Sickness, an Insured Person requires the service of a licensed nurse or licensed practical nurse during a Hospital Confinement, We will pay the Covered Percentage of the Covered Charges incurred subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.]

[OPTIONAL HOSPICE EXPENSE BENEFIT

If an Insured Person is Terminally Ill and requires a coordinated plan of home and inpatient care, We will cover charges for hospice services furnished to the Insured Person on the same basis as any other Sickness. The services must be under active management through a licensed hospice and approved by Us.

Covered Services will include:
(a) part-time intermittent home nursing care by or under the direction of a graduate Registered Nurse;
(b) medical supplies, equipment, and medication required to maintain the comfort and manage the pain of the Terminally Ill Insured Person.
(c) counseling, including dietary counseling, for the Terminally Ill Insured Person;
(d) Family Counseling for the immediate family and the family caregiver before the death of the Terminally Ill Insured Person;
(e) Bereavement Counseling for the immediate family or family caregiver of the Insured for at least the 6 month period following the Insured Person’s death or 15 visits, whichever occurs first.

What We pay is shown in the Plan of Insurance.

Definitions

Terminally Ill means a medical prognosis given by a Doctor that the Insured Person’s life expectancy is six months or less.

Bereavement Counseling means counseling provided to the immediate family or family caregiver of the insured after the Insured Person’s death to help the immediate family or family caregiver cope with the death of the Insured Person.

Family Counseling means counseling given to the immediate family or family caregiver of the Terminally Ill Insured Person for the purpose of learning to care for the Insured Person and to adjust to the death of the Insured Person.]

[PRE-ADMISSION TESTS EXPENSE BENEFIT *included if mandated by state*

Notwithstanding any provision in the Policy to the contrary, We will pay benefits for Covered Charges made by a Hospital for use of its outpatient facilities for tests ordered by a Doctor. The tests must be performed as a planned preliminary to the Insured Person's admission as an inpatient for surgery in that same Hospital. However: (a) the test must be necessary for, and consistent with, the diagnosis and treatment of the condition for which surgery is to be performed; (b) reservations for a Hospital bed and for an operating room must be made prior to the date the tests are done; (c) the surgery actually takes place within [seven] days of pre-surgical tests; and (d) the Insured Person is physically present at the Hospital for the tests.

No benefit shall be payable under this provision in excess of either: (1) the benefits that would have been provided under this Policy had the Insured Person received those tests while confined in the Hospital as a resident bed-patient; or (2) the Miscellaneous Hospital Expense Maximum shown in the Plan of Insurance for the Miscellaneous Hospital Expense Benefit.

If, by reason of similar benefit provisions elsewhere contained, the Policy provides for reimbursement for the same charges, no benefits shall be payable under these provisions, except to the extent by which the amount of benefit produced under those provisions for a given charge exceeds the amount of benefits produced for that same charge under this provision.

This provision shall apply with respect to the Insured Person only to the extent that the Insured Person is insured under this Policy for Hospital Expense Benefits.

What We pay is shown in the Plan of Insurance.]

[PRESCRIPTION DRUG EXPENSE BENEFIT

If by reason of Injury or Sickness, an Insured Person requires drugs, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for such drugs and the Medically Necessary services associated with the administration of such drugs, subject to the Copayment shown in the Plan of Insurance.

The drugs must be prescribed by a Doctor. We only cover drugs which are approved for the treatment of the Insured Person's Injury or Sickness by the Food and Drug Administration. We will also cover a drug prescribed for a treatment for which it has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established reference compendia:

(1) the American Medical Association Drug Evaluations;
(2) the American Hospital Formulary Service Drug Information;
(3) the United States Pharmacopoeia Drug Information; or
(4) it is recommended by a clinical study or review article in two major peer-reviewed professional journals that present data supporting the use or uses to be generally safe and effective.

Also covered are prescription drugs or devices approved by the federal Food and Drug Administration for use as a contraceptive.

However, Covered Charges do not include experimental or investigational drugs or any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed or for any drug or device intended to induce an abortion.

What We pay is shown in the Plan of Insurance.]

[PROSTHETICS APPLIANCE AND ORTHOTIC DEVICE EXPENSE BENEFIT

If, by reason of Injury or Sickness, an Insured Person requires the use of a Prosthetic Appliance or Orthotic Device, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for the purchase, initial fitting, and needed adjustment of such appliances or devices, as shown in the Plan of Insurance.

We do not pay for the replacement of Prosthetic Appliances or Orthotic Devices.

What We pay is shown in the Plan of Insurance.

Definitions

Prosthetic Appliance means a device, or artificial appliance, that: (1) maintains or replaces the body part of an Insured Person whose covered Injury or Sickness has required the removal of that body part; and (2) is prescribed by the Insured Person's Doctor who documents the necessity for the item.

Orthotic Device means a mechanical device, such as braces (but not dental) or shoes, that: (1) is directly related to the treatment of an Injury or Sickness; and (2) is prescribed by the Insured Person's Doctor who documents the necessity for the item.]

[SICKNESS DENTAL EXPENSE BENEFIT

If, by reason of Sickness, an Insured Person requires treatment for impacted wisdom teeth or dental abscesses, We will pay the Covered Percentage of the Covered Charges incurred subject to the Deductible shown in the Plan of Insurance.

What We pay is shown in the Plan of Insurance.]

[SKILLED NURSING FACILITY EXPENSE BENEFIT

If an Insured Person requires continuing treatment in a Skilled Nursing Facility following hospitalization, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for treatment in such Skilled Nursing Facility.

The services must be Medically Necessary as a continuation of treatment for the condition for which the Insured Person was previously hospitalized. The Insured Person must be admitted to the Skilled Nursing Facility **[**within 24 hours**]** following a Medically Necessary Hospital stay.

We cover such charges the same way We treat Covered Charges for any Hospital Confinement.

What We pay is shown in the Plan of Insurance.

Definition:
Skilled Nursing Facility means a facility that is primarily engaged in providing inpatient skilled nursing care and related services to patients requiring convalescent and rehabilitative care. The facility must:

(a) be directed by a duly licensed Doctor;
(b) provide continuous 24 hour a day nursing service by or under the supervision of a registered graduate professional nurse (RN);
(c) maintain a daily medical record of each patient;
(d) be operated pursuant to law and appropriately licensed or certified;
(e) be certified by the Medicare program.

Such facility must not include any home, facility or part thereof, used primarily:
(a) for rest or treatment of tuberculosis;
(b) for the aged, or for the care of drug addiction;
(c) for the care and treatment of mental diseases or disorders, or custodial or educational care.]

[STUDENT HEALTH CENTER REFERRAL

In order to obtain the maximum benefit available when medical treatment is needed, the Insured Student must go to the Student Health Center (SHC) first where treatment will be administered or a referral issued. **[**Such charges are subject to the Deductible.] Expenses incurred for medical treatment rendered outside of the Student Health Center for which no prior approval or referral is obtained [are excluded from coverage] [will be paid at {80%} of the benefits otherwise payable under the Plan of Insurance]. A referral issued by the SHC must accompany the claim when submitted.

A SHC referral for outside care is not necessary only under the following conditions:
(1) [Medical Emergency; (The student [and Dependent] must return to SHC for necessary follow-up care.)]
(2) [When the Student Health Center (SHC) is closed;]
(3) [When service is rendered at another facility during break or vacation periods;]
(4) [Medical care received when the student is more than {50} miles from campus;]
(5) [Medical care obtained when a student is no longer able to use the SHC due to a change in students status;]
(6) [Maternity; or]
(7) [Psychotherapy.]

[Dependents are not eligible to use the SHC; and therefore, are exempt from the above limitations and requirements.]]

[EMERGENCY MEDICAL EVACUATION EXPENSE BENEFIT

This benefit applies only to [Domestic Students [while Studying Abroad],] [International Students,] [and their Dependents]. This benefit will pay benefits for the Covered Percentage of the Covered Expenses incurred, if any Injury [or Sickness] results in the Emergency Medical Evacuation of the Insured Person.

What We pay is shown in the Plan of Insurance.

Definitions:

Emergency Medical Evacuation means:
(a) the Insured Person's medical condition warrants immediate Transportation from the place where the Insured Person is injured or ill to the nearest Hospital [or home residence] where appropriate medical treatment can be obtained; or
(b) for [Domestic Students while Studying Abroad,] [International Students,] [and their Dependents] after being treated at a local Hospital; the Insured Person's medical condition warrants Transportation to his/her Home Country to obtain further medical treatment to recover.

Covered Expenses are Expenses up to the maximum stated in the Plan of Insurance for: (a) Transportation, (b) medical services, and (c) medical supplies necessarily incurred in connection with Emergency Medical Evacuation of the Insured Person. All Transportation arrangements made for evacuating the Insured Person must be: (a) by the most direct and economical conveyance; and (b) approved in advance by the Company.

Home Country means the country from which the Insured Person holds a passport. Where the Insured Person holds more than one passport, the Home Country will be the country that the Insured Person has declared with the Company.

Transportation means any land, water or air conveyance required to transport the Insured Person during an Emergency Medical Evacuation. Expenses for special transportation must be: (a) recommended by the attending Doctor; or (b) required by the standard regulations of the conveyance transporting the Insured Person. Special transportation includes, but is not limited to: air ambulance, land ambulance, and private motor vehicle. Expenses for medical supplies and services must be recommended by the attending Doctor.]

[REPATRIATION OF BODY REMAINS EXPENSE BENEFIT
This benefit applies only to [Domestic Students [while Studying Abroad],] [International Students,] [and their Dependents]. In the event of the death of an Insured Person, We will pay the actual charges for the Covered Expenses for the preparation and transportation of the Insured Person's remains to his or her Home Country [or home residence]. This will be done in accord with all legal requirements in effect at the time the body remains are to be returned to his or her Home Country. The death must occur while the person is insured for this benefit.

What We pay is shown in the Plan of Insurance.

Definitions

Covered Expenses include, but are not limited to, Expenses for embalming, cremation, coffins, and transportation.

Home Country means the country from which the Insured Person holds a passport. Where the Insured Person holds more than one passport, the Home Country will be the country that the Insured Person has declared with the Company.]

[CHILD IMMUNIZATION EXPENSE BENEFIT *included if dependent children covered and mandated for accident and sickness*

We will pay the Covered Charges incurred for immunizations of a covered Dependent child from birth to five (5) years of age. We cover such charges the same way We treat Covered Charges for any other Sickness, except Covered Charges for this benefit are not subject to any Deductible or Copayment provisions.

What We pay is shown in the Plan of Insurance.]

[DENTAL ANESTHESIA AND HOSPITALIZATION EXPENSE BENEFIT *included if mandated*

We will pay the Covered Percentage of the Covered Charges incurred for the administration of general anesthesia and Hospital and licensed ambulatory surgical facility charges for dental care provided to an Insured Person in such Hospital or ambulatory surgical facility if:

(a) The Doctor treating the Insured Person certifies that because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedure; and

(b) The patient:

(1) is a child under the age of seven who is determined by 2 dentists licensed under Arkansas law to require without delay necessary dental treatment in a hospital or ambulatory surgical center for significantly complex dental condition; or

(2) a person with a diagnoses serious mental or physical dondition; or

(3) a person with a significant behavioral problem as determined by the covered person's physician as licensed under the Arkansas Medical Practice Act.

Treatment may be provided by a dentist in either a Hospital or licensed ambulatory surgical facility.

We cover such charges the same way We treat Covered Charges for any other Injury or Sickness.

What We pay is shown in the Plan of Insurance.]

[ENTERAL FORMULA EXPENSE BENEFIT *included if dependent children covered and mandated for accident and sickness*

We will pay the Covered Percentage of the Covered Charges incurred for a formula or formulas recommended by a Doctor for the treatment of an Insured Person who is less than six (6) years of age with phenylketonuria or any inherited disease of amino or organic acids.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.]

[**BREAST RECONSTRUCTION AFTER MASTECTOMY EXPENSE BENEFIT** *included if mandated for accident and sickness*

If an Insured Person who is receiving benefits under the Policy in connection with a mastectomy elects breast reconstruction in connection with such mastectomy, Covered Charges include those incurred for:

(a) reconstruction of the breast on which the Mastectomy has been performed;
(b) surgery and reconstruction of the nondiseased breast To Restore and Achieve Symmetry;
(c) Prosthetic Devices and treatment of physical complications for all stages of a Mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes); and
(d) hospitalization, for a length of stay as determined by the attending Doctor and surgeon in consultation with the Insured Person, and consistent with sound clinical principles and processes

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

Definitions

Coverage for Prosthetic Devices or Reconstructive Surgery means any initial and subsequent reconstructive surgeries or Prosthetic Devices, and follow-up care deemed necessary by the attending Doctor and surgeon.

Prosthetic Devices means the provision of initial and subsequent devices pursuant to an order of the patient's Doctor and surgeon.

Mastectomy means the removal of all or part of the breast for Medically Necessary reasons, as determined by a licensed Doctor and surgeon.

To Restore and Achieve Symmetry means that, in addition to Coverage for Prosthetic Devices or Reconstructive Surgery for the diseased breast on which the Mastectomy was performed, Prosthetic Devices and reconstructive surgery for the healthy breast is also covered if, in the opinion of the attending Doctor and surgeon, this surgery is necessary to achieve normal symmetrical appearance.]

[NEWBORN HEARING SCREENING EXPENSE BENEFIT *included if dependent children covered and mandated for accident and sickness*

We will pay the Covered Percentage of the Covered Charges incurred for hearing screening, necessary rescreening, audiological assessment and follow-up and initial amplification for a newborn Dependent.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.]

[OSTEOPOROSIS EXPENSE BENEFIT *included if mandated for accident and sickness*

We will pay the Covered Percentage of the Covered Charges incurred for diagnosis, treatment and appropriate management of osteoporosis for Insured Persons with a condition or medical history for which bone mass measurement is medically indicated. In determining whether testing or treatment is medically appropriate the Doctor shall give due consideration to peer reviewed medical literature.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.]

[**OPTIONAL CHILD HEALTH SUPERVISION SERVICES EXPENSE BENEFIT** *included if dependent children covered and mandated for accident and sickness*

We will pay the Covered Percentage of the Covered Charges incurred for Child Health Supervision Services for a covered Dependent child from the moment of birth to 12 years of age. Such services will be provided at approximately the following

age intervals: birth; two (2) months; four (4) months; six (6) months; nine (9) months; 12 months; 18 months; two (2) years; three (3) years; four (4) years; five (5) years; six (6) years; eight (8) years; ten (10) years and 12 years.

Benefits are limited to one visit payable to one provider for all of the services at each visit.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

Definition:

Child Health Supervision Services means the periodic review of a covered Dependent child's physical and emotional status by a Doctor or pursuant to a Doctor's supervision. A review shall include: a) a history; b) physical examination; c) developmental assessment; d) anticipatory guidance; e) appropriate immunizations; and f) laboratory tests, in keeping with prevailing medical standards.]

BREAST CANCER EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to a nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants.

We cover such charges the same way We treat Covered Charges for any other Sickness, except that the Lifetime Maximum Benefit payable for each Insured Person is limited to $100,000.

What We pay is shown in the Plan of Insurance.

LOSS/IMPAIRMENT OF SPEECH/HEARING EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for the Medically Necessary care and treatment of the Loss or Impairment of Speech or Hearing.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

Definition

Loss or Impairment of Speech or Hearing means those communicative disorders generally treated by a speech pathologist, audiologist or speech language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA) or both and which fall within the scope of his or her license or certification.

DIABETES EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for Doctor prescribed Medically Necessary equipment, supplies and self-management training used in the management and treatment of Diabetes.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

Definition: Diabetes means an Insured Person with gestational, type I or type II diabetes.

LEAD POISONING TESTING EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for the testing of insured pregnant women for lead poisoning and for all testing for lead poisoning authorized by Missouri law or regulation.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

[OPTIONAL CHEMICAL DEPENDENCY AND MENTAL ILLNESS EXPENSE BENEFIT

A. Covered Charges for Treatment of Chemical Dependency

We will pay the Covered Percentage of the Covered Charges incurred for the Medically Necessary care and treatment of Chemical Dependency on the same basis as for any other Sickness, subject to the following limits:

1. Outpatient treatment through a Nonresidential Treatment Program or through partial- or full-Day Program Services, up to 26 days per Policy Year.
2. Residential Treatment Program, up to 21 days per Policy Year.
3. Medical and Social Setting Detoxification, up to six (6) days per Policy Year.
4. Lifetime limit of 10 Episodes of treatment per Insured Person, except that this frequency maximum will not apply to Medical Detoxification in a life-threatening situation as determined by the treating Doctor and subsequently documented within 48 hours of treatment to our reasonable satisfaction.

B. Covered Charges for Treatment of Recognized Mental Illness

We will pay the Covered Percentage of the Covered Charges incurred for the Medically Necessary care and treatment of Recognized Mental Illness (excluding Chemical Dependency) to the same extent as any other covered Sickness for the following services:

1. Outpatient treatment, including treatment through partial or full-Day Program Services, for mental health services rendered by a licensed professional, {20-60} visits per Policy Year.
2. Residential treatment programs for therapeutic care when prescribed by a licensed professional and rendered in a psychiatric Residential Treatment Center.
3. Inpatient Hospital treatment,{30 – 90} days per Policy Year.

[We may administer the above Covered Charges through a Managed Care Program established by Us. Covered services may be delivered through a system of contractual arrangements with one or more providers, Hospitals, Nonresidential or Residential Programs or other mental health service delivery entities certified by the Missouri Department of Mental Health or accredited by a nationally recognized organization or licensed by the state of Missouri.**]**

C. Covered Charges for Other Mental Health Benefits

We will pay the Covered Percentage of the Covered Charges incurred for two sessions per Policy Year with a licensed psychiatrist, licensed psychologist, licensed professional counselor or licensed clinical social worker who is acting within the scope of such license on the same basis as for any other Sickness, subject to the following:

1. Care must be for the purpose of diagnosis or assessment, but not dependent upon findings;
2. Services are not subject to prior approval, pre-authorization or pre-certification and are reimbursable as long as the provisions of this benefit are satisfied;
3. Benefits are subject to the same Coinsurance, Copayment and Deductible factors of the Policy that apply to regular office visits for physical Sickness.

What We pay is shown in the Plan of Insurance.

Definitions:

Chemical Dependency means the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

Community Mental Health Center means a legal entity certified by the Missouri Department of Mental Health or accredited by a nationally recognized organization, through which a comprehensive array of mental health services are provided to individuals.

Day Program Services means a structured, intensive day or evening treatment or partial hospitalization program, certified by the Missouri Department of Mental Health or accredited by a nationally recognized organization.

Episode means a distinct course of Chemical Dependency treatment separated by at least 30 days without treatment.

Licensed Professional means a licensed Doctor specializing in the treatment of mental illness, a licensed psychologist, a licensed clinical social worker or a licensed professional counselor.

Managed Care means the determination of availability of coverage through the use of clinical standards to determine the medical necessity of an admission or treatment, and the level and type of treatment, and appropriate setting for treatment, with required authorization on a prospective, concurrent or retrospective basis, some involving case management.

Medical Detoxification means Hospital inpatient or residential medical care to ameliorate acute medical conditions associated with Chemical Dependency.

Nonresidential Treatment Program means a program certified by the Missouri Department of Mental Health involving structured, intensive treatment in a nonresidential setting.

Recognized Mental Illness means the following disorders contained in the International Classification of Diseases (ICD-9-CM):
(a) Schizophrenic disorders and paranoid states (295 and 297, except 297.3);
(b) Major depression, bipolar disorder, and other affective psychoses (296);
(c) Obsessive compulsive disorder, post-traumatic stress disorder and other major anxiety disorders (300.0, 300.21, 300.22, 300.23, 300.3 and 309.81);
(d) Early childhood psychoses, and other disorders first diagnosed in childhood or adolescence (299.8, 312.8, 313.81 and 314);
(e) Alcohol and drug abuse (291, 292, 303, 304, and 305, except 305.1); and
(f) Anorexia nervosa, bulimia and other severe eating disorders (307.1, 307.51, 307.52 and 307.53);
(g) Senile organic psychotic conditions (290).

Residential Treatment Program means a program certified by the Missouri Department of Mental Health involving residential care and structured, intensive treatment.

Social Setting Detoxification means a program in a supportive nonhospital setting designed to achieve detoxification, without the use of drugs or other medical intervention to establish a plan of treatment and provide for medical referral when necessary.]

[The Policyholder will choose either the Chemical Dependency And Mental Illness Expense Benefit or the Alcoholism Treatment Expense Benefit.]

[OPTIONAL ALCOHOLISM TREATMENT EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for the treatment of alcoholism in a Hospital or in a residential or nonresidential facility certified by the Arkansas Department of Mental Health the same as any other Sickness, subject to a Policy Year maximum of 30 days per confinement.

What We pay is shown in the Plan of Insurance.**]**

[RECONSTRUCTIVE SURGERY EXPENSE BENEFIT

We cover charges for Reconstructive Surgery that is necessary to improve function or create a normal appearance.

Exception:
Cosmetic Surgery is performed to alter or reshape normal structures of the body in order to improve the patient's appearance and is therefore **not** a Covered Charge.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

Definitions:

Reconstructive Surgery means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:
(a) to improve function; and
(b) to create a normal appearance, to the extent possible.]

[SEVERE MENTAL ILLNESS (ADULTS AND CHILDREN)
AND SERIOUS EMOTIONAL DISTURBANCES OF CHILDREN EXPENSE BENEFIT *included if mandated for accident and sickness*

If an Insured Person requires treatment for Severe Mental Illness, We will pay for such treatment of a person of any age and for Serious Emotional Disturbances of a Child under the same terms and conditions applied to other medical conditions.

The benefits shall include to following:
(a) outpatient services;
(b) inpatient Hospital services;
(c) partial Hospital services; and
(d) prescription drugs, if the Policy includes prescription drug coverage.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

Definitions

Severe Mental Illness shall include: Schizophrenia; Schizoaffective disorder; Bipolar disorder (manic-depressive illness); Major depressive disorders; Panic disorder; Obsessive-compulsive disorder; Pervasive developmental disorder or autism; Anorexia nervosa; and Bulimia nervosa.

Serious Emotional Disturbances of a Child means a child who: (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms; and (2) meets the criteria of applicable state law.]

[SIGMOIDOSCOPIC EXPENSE BENEFIT

If an Insured Person requires a Sigmoidoscopic exam, We will pay the Covered Percentage of the Covered Charges incurred for Sigmoidoscopic exams.

Benefits will be paid for Sigmoidoscopic exam charges incurred for the following:

(a) One baseline Sigmoidoscopy at age fifty through fifty-five; and
(b) One Sigmoidoscopy every three to five years thereafter. If preferred, an annual fecal occult blood test may be alternatively used.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

Definition:

Sigmoidoscopy means inspection through an endoscope of the interior of the sigmoid colon for the purposes of identifying liason(s) including polyps, cancer, ulceratrions, or diverticulum.]

[OPTIONAL TEMPOROMANDIBULAR JOINT/CRANIOMANDIBULAR DISORDER EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for surgical and non-surgical treatment of a temporomandibular joint and/or craniomandibular disorder.

We cover such charges the same way We treat Covered Charges for any other Sickness. But, We will not pay more than $3,000 in an Insured Person's lifetime.

What We pay is shown in the Plan of Insurance.]

[TREATMENT OF MORBID OBESITY EXPENSE BENEFIT

If an Insured Person requires treatment for Morbid Obesity, We will pay the Covered Percentage of the Covered Charges incurred for medically diagnosed morbid obesity in accordance with medically established and approved treatment protocol.

We cover such charges the same was We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.]

[CLINICAL TRIALS FOR PREVENTION, EARLY DETECTION AND TREATMENT OF CANCER EXPENSE BENEFIT
included if mandated for accident and sickness

We will pay the Covered Percentage of the Covered Charges incurred for Routine Patient Care Costs as the result of phase II, III, or IV of a clinical trial that is approved by an Entity and is undertaken for the purposes of the prevention, early detection, or treatment of cancer.

In the case of treatment under a clinical trial, the treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. There must be equal to or superior, noninvestigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the noninvestigational alternatives.

Coverage shall include coverage for routine patient care costs incurred for drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, including coverage for reasonable and medically necessary services needed to administer the drug or use the device under evaluation in the clinical trial.

Coverage for routine patient care costs shall apply to phase III or IV of clinical trials that are approved or funded by an Entity.

Coverage for routine patient care costs shall apply to phase II of clinical trials if:

(1) Phase II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and

(2) The person covered under this section is enrolled in the clinical trial. This section shall not apply to persons who are only following the protocol of phase II of a clinical trial, but not actually enrolled.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

Definitions

Entity means any of the following:

(1) One of the National Institutes of Health (NIH);

(2) An NIH cooperative group or center as defined in subsection 7 of this section;

(3) The FDA in the form of an investigational new drug application;

(4) The federal Departments of Veterans' Affairs or Defense;

(5) An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects (45 CFR 46); or

(6) A qualified research entity that meets the criteria for NIH Center support grant eligibility.

Cooperative group means a formal network of facilities that collaborate on research projects and have an established NIH-approved Peer Review Program operating within the group, including the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;

Multiple project assurance contract means a contract between an institution and the federal Department of Health and Human Services (DHHS) that defines the relationship of the institution to the DHHS and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects;

Routine patient care costs mean coverage for reasonable and medically necessary services needed to administer the drug or device under evaluation in the clinical trial. Routine patient care costs include all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

(a) The investigational item or service itself;

(b) Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and

(c) Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.**]**

[ANNUAL ROUTINE EXAM EXPENSE BENEFIT

We will pay the Covered Charges for an annual routine physical exam or gynecological exam up to a maximum of $150.00 per policy year.]

[BREAST IMPLANT REMOVAL EXPENSE BENEFIT

We cover charges for the Medically Necessary removal of breast implants, including implants that involved cosmetic surgery performed for reasons of reconstruction, that were done as a result of Injury or Sickness. However, removal of breast implants is not covered if the surgery was done solely for cosmetic reasons.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.]

[INFERTILITY EXPENSE BENEFIT *included if mandated for accident and sickness*

We cover charges for the diagnosis and treatment of infertility including, but not limited to: in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and low tubal ovum transfer. Cryopreservation, the procedure whereby embryos are frozen for late implantation, shall be included as an in vitro fertilization procedure.

Benefits, for the above procedures will only be paid regardless of the Experimental or Investigational nature of such procedures. We cover such charges the same way We treat Covered Charges for any other Sickness subject to the following conditions:

(1) The patient is the Insured Student or the spouse of the Insured Student and a covered dependent under the Policy, and

(2) The patient's oocytes are fertilized with the sperm if the patient's spouse, and

(3) (a) The patient and the patient's spouse have a history of unexplained infertility of at least 2 years' duration; or (b) The infertility is associated with one or more of the following medical conditions: endometriosis;, exposure to Diethylstilbestrol, commonly known as DES; blockage of or a removal of one or both fallopian tubes (lateral or bilateralsalpingectomy) not a result of voluntary sterilization, or abnormal male factors contributing to the infertility, and

(4) The in vitro fertilization procedures are performed at a medical facility, licensed or certified by the Arkansas Department of Health, those performed at a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization, and

(5) The patient has been unable to obtain successful pregnancy through less costly applicable infertility treatment for which coverage is available under the policy.

What We pay is shown in the Plan of Insurance.]

[MASTECTOMY EXPENSE BENEFIT *included if mandated for accident and sickness*

We cover charges for prosthetic devices; and reconstructive surgery incident to a mastectomy.

Coverage for prosthetic devices and reconstructive surgery will be subject to the Deductible and Covered Percentage provisions shown in the Plan of Insurance and is limited to two years after performance of a covered mastectomy which had revealed no evidence of malignancy.

What We pay is shown in the Plan of Insurance.]

Definition

Mastectomy means the removal of all or part of the breast for reasons that are determined by a licensed Doctor to be Medically Necessary.]

[POST-MASTECTOMY EXPENSE BENEFIT *included if mandated for accident and sickness*

We cover charges for: (a) inpatient coverage following a mastectomy for a length of time determined by the attending Doctor to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence; and (b) a post-discharge Doctor office visit or in-home nurse visit to verify the condition of the patient in the first 48 hours after discharge.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.]

[PEDIATRIC PREVENTIVE CARE EXPENSE BENEFIT *included if dependent children covered and mandated for accident and sickness*

We cover charges for preventive services rendered to a child enrolled as a dependent including physical examinations, immunizations, history measurements, sensory screening, neuropsychiatric evaluation and development screening and assessment at the following intervals: (a) six times during the first year after birth; (b) up to a maximum of three times during the next year; and (c) annually until age 6.

Such charges will not be subject to a Deductible, if any.

What We pay is shown in the Plan of Insurance.]

[PROSTATE-SPECIFIC ANTIGEN EXPENSE BENEFIT *included if mandated for accident and sickness*

If an Insured Person requires a Prostate-Specific Antigen test, We will pay the Covered Percentage of the Covered Charges incurred for one annual digital rectal examination and a Prostate-Specific Antigen Test, for male insureds upon the recommendation of a Doctor licensed to practice medicine in all its branches for:

(a) Asymptomatic men age 50 and over;
(b) African-American men age 40 and over; and
(c) Men age 40 and over with a family history of prostate cancer.

What We pay is shown in the Plan of Insurance.]

[DAY SURGERY MISCELLANEOUS EXPENSE BENEFIT

We cover charges for day surgery miscellaneous expenses related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies.

Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.

What We pay is shown in the Plan of Insurance.]

TELEMEDICINE MEDICAL SERVICE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred as shown in the Plan of Insurance for Telemedicine.

Prior to the delivery of health care via telemedicine, a Doctor who has ultimate authority over the care or primary diagnosis of the patient shall obtain verbal and written informed consent from the patient or the patient's legal representative. The informed consent procedure shall ensure that at least all of the following information is given to the patient or the patient's legal representative verbally and in writing:

(1) The patient or the patient's legal representative retains the option to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which the patient or the patient's legal representative would otherwise be entitled.

(2) A description of the potential risks, consequences, and benefits of telemedicine.

(3) All existing confidentiality protections apply.

(4) All existing laws regarding patient access to medical information and copies of medical records apply.

(5) Dissemination of any patient identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without the consent of the patient.

A patient or the patient's legal representative shall sign a written statement prior to the delivery of health care via telemedicine, indicating that the patient or the patient's legal representative understands the written information provided and that this information has been discussed with the Doctor.

The written consent statement signed by the patient or the patient's legal representative shall become part of the patient's medical record.

Definition

Telemedicine
This term means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medicaldata, and education using interactive audio, video, or data communications. Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient constitutes “telemedicine”.

Interactive
This term means an audio, video, or data communication involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information.

[**PHENYLKETONURIA EXPENSE BENEFIT**

We will cover charges for amino acid modified preparations, low protein modified food products, and any other special dietary products and formulas prescribed under the direction of a physician for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism, that are part of a diet prescribed by a licensed Doctor and managed by a health care professional in consultation with a Doctor who specializes in the treatment of metabolic disease. Such coverage is provided if the diet is deemed Medically Necessary to avoid the development of serious physical or mental disabilities or to promote normal development for function as a consequence of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism

[We cover such charges the same way We treat Covered Charges for any other Sickness.]

What We pay is shown in the Plan of Insurance.

Definitions

Formula
This term means an enteral product or enteral products for use at home that are prescribed by a Doctor or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments, as Medically Necessary for the treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism.

Coverage is not required except to the extent that the cost of necessary Formulas and Special Food Products exceeds the cost of a normal diet.

Special Food Products
This term means a food product that is both of the following:

(a) prescribed by a Doctor or nurse practitioner for the treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism, and is consistent with the recommendations and best practices of qualified health professionals with expertise and experience in the treatment and care of such conditions or disorders. It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving; and
(b) used in place of normal food products, such as grocery store foods, used by the general population.]

[PREVENTIVE CARE FOR DEPENDENT CHILDREN EXPENSE BENEFIT

We cover charges for one visit for children's preventive health care services for a covered Dependent at each of the following age intervals:

(A) Birth;
(B) 2 weeks;
(C) 2 months;
(D) 4 months;
(E) 6 months;
(F) 9 months;
(G) Twelve months;
(H) Fifteen months;
(I) Eighteen months;
(J) 2 years;
(K) 3 years;
(L) 4 years;
(M) 5 years;
(N) 6 years;
(O) 8 years;
(P) 10 years;
(Q) Twelve years;
(R) Fourteen years;
(S) Sixteen years; and
(T) Eighteen years.

Benefits are limited to one Doctor (provider) per visit for all services rendered.

Benefits for recommended immunization services are exempt from any copayment, coinsurance, deductible, or dollar limit provisions in the policy. All other children's preventive health care services will be paid as any other Sickness.

What We pay is shown in the Plan of Insurance.**]**

Definitions:

Children's preventive health care services means physician-delivered or physician-supervised services for eligible dependents from birth through eighteen (18) years of age, with periodic preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards.

Periodic preventive care visits means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.]

GENERAL EXCLUSIONS AND LIMITATIONS

The Policy does not cover nor provide benefits for:

1. [Services normally provided without charge by the Policyholder's student health service center, infirmary, or Hospital, or by Health Care Providers employed by the Policyholder;]

2. [Preventative medicines, serums, immunizations, or vaccines, except as specifically provided;]

3. [Speech therapy treatment, except as specifically provided;]

4. [Private duty nursing or skilled nursing services, except as specifically provided;]

5. [Home health care services, except as specifically provided;]

6. [Care and/or treatment in skilled nursing facility, except as specifically provided;]

7. [Organ transplants, except as specifically provided;]

8. [Hospice services, except as specifically provided;]

9. [Pre-existing Conditions as defined in this Policy.]

10. [Nonprescription drugs or medicines;]

11. [Injury sustained or Sickness contracted while in service of the Armed Forces of any country, except as specifically provided. Upon the Insured Person entering the Armed Forces of any country, We will refund the unearned pro-rata premium to such Insured Person;]

12. [Illness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with [intercollegiate sports], [intercollegiate club sports], [and professional sports];]

13. [Injury resulting from motor vehicle accident to the extent that benefits are payable under any automobile medical expense insurance or automobile no-fault plans;]

14. [Cosmetic surgery, except as the result of covered Injury occurring while this Policy is in force as to the Insured Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect;]

15. [Illness, Accident, treatment or medical condition arising out of hang-gliding, skydiving, glider flying, parasailing, sail planing, bungee jumping, racing or speed contests, skin diving, parachuting or bungi-cord jumping;]

16. [Correction of congenital defects except as specifically provided;]

17. [Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law;]

18. [Services incurred prior to the Insured Person's Effective Date or during Hospital Confinement in one or more facilities which began prior to the Insured Person's Effective Date;]

19. [Expense incurred as the result of dental treatment, except as provided in the Sickness Dental Expense Benefit, if included in this Policy. This exclusion does not apply to treatment resulting from Injury to natural teeth;]

20. [Expense incurred for treatment of temporomandibular joint dysfunction and associated myofacial pain, except as specifically provided;]

21. [Expense incurred after the date insurance terminates for an Insured Person except as may be specifically provided in the Extension of Benefits Provision, when applicable;]

22. [Medical services that are not Medically Necessary or that do not conform with medical standards of practice within the community. Also services and supplies in connection with Experimental or Investigational Care for the terminally ill;]

23. [Injury or Sickness resulting from declared or undeclared war; or any act thereof;]

24. [Charges for treatment of any Injury or Sickness due to an Insured Person's commission of, or attempt to commit a felony, or a crime which would be considered a felony if prosecuted;]

25. [Injury due to participation in a riot;]

26. [Charges for which Insured Persons have no legal obligation to pay in absence of this or like coverage;]

27. [For services or supplies rendered by a close relative of the Insured Person. By “close relative” We mean an Insured Person’s spouse, children, parents, brothers and sisters;]

28. [Personal hygiene/convenience items; telephone consultations, missed appointments, photocopies or medical records, or completion of claim forms; expenses incurred for custodial care or services not needed to diagnose or treat an Injury or Sickness, including but not limited to services related to the activities of daily living;]

29. [For services, supplies or treatment, including any period of Hospital Confinement, which were not recommended, approved and certified as necessary and reasonable by a Doctor; or expenses non-medical in nature;]

30. [Expenses incurred in connection with foot care only to improve comfort or appearance such as care for weak, strained or flat feet; subluxation; corns; calluses; bunions, except open cutting operations; routine care of toenails, except for the removal of the nail root and necessary services in treatment of metabolic or peripheral-vascular disease; treatment of the instability and imbalance of the feet; and any tarsalgia, metatarsalgia. Expenses incurred for the care and treatment of Injury, infection, or disease are not excluded;]

31. [Screening examinations, including X-ray examinations made without film, except as specifically provided;]

32. [Expenses incurred in connection with family planning, the enhancement of fertility, fertility tests, correction of infertility, in-vitro fertilization, artificial insemination, and services or supplies for inducing conception;]

33. [Expenses incurred in connection with a voluntary sterilization procedure or any sterilization reversal process;]

34. [Inpatient charges for physical therapy or diagnostic services if physical therapy and diagnostic services are available on an outpatient basis;]

35. [Physical therapy unless recommended by the Student Health Center;]

36. [Treatment of obesity, including any care which is primarily dieting or exercise for weight loss, except for surgical treatment of morbid obesity;]

37. [Expenses incurred for transsexual surgery or any treatment leading to or in connection with transsexual surgery;]

38. [Marriage, family, and group counseling;]

39. [Services or supplies primarily for educational, vocational or training purposes, except the initial visit to diagnose and determine if a medical condition is causing a learning disability;]

40. [Expense incurred for eye examinations or prescriptions, eyeglasses, and contact lenses (except for sclera shells which are intended for use of corneal bandages), eye refractions, vision therapy, multiphasic testing, or lasix or other vision procedures except as required for repair caused by a covered Injury;]

41. [Well baby care, including routine exams and immunizations, except as specifically provided;]

42. [Routine periodical physical examinations [and routine chest x-rays], except as specifically provided;]

43. [Expenses incurred for allergy testing [and allergy treatment];]

44. [Treatment provided in a governmental Hospital unless there is a legal obligation to pay such charges in the absence of insurance;]

45. [Blood plasma, except charges by a Hospital for the processing or administration of blood;]

46. [Expenses for any service or supply not specified in this Policy as a covered service;]

47. [An amount of a charge in excess of the Reasonable and Customary Expense;]

48. [Elective Treatment or elective surgery, except as specifically provided;]

49. [Services not Medically Necessary;]

50. [Oral contraceptives and other forms of contraception used for contraceptive purposes only, except as specifically provided;]

51. [Expenses for emergency room treatment for an Injury or Sickness not a Medical Emergency as defined in this Policy, including emergency "follow-up" visits;]

52. [Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route;]

53. [Treatment of mental or nervous disorders except as specifically provided;]

54. [Treatment of alcohol and substance abuse except as specifically provided;]

55. [For International Students, expenses incurred within the Insured Person's Home Country or Country of regular domicile;]

56. [[In Missouri - suicide, attempted suicide, or intentionally self-inflicted injury only while sane;] **[**Suicide, attempted suicide, or intentionally self-inflicted injury [while sane, or insane except in Missouri;]]]

57. [Injuries incurred by the Insured Person while intoxicated or under the influence of any drug unless taken as prescribed by a Doctor;]

58. [Expense incurred for: [tubal ligation;][vasectomy;] breast implants; breast reduction; sexual reassignment surgery; impotence (organic or otherwise); non-cystic acne; non-prescription birth control; submucus resection and/or other surgical correction for deviated nasal septum, other than for required treatment of acute purulent sinusitis; circumcision; gynecomastia; hirsutism; [and learning disabilities or disorders or Attention Deficit Disorder;]]

59. [Voluntary or elective abortion; [pregnancy of a dependent child], except as specifically provided;]

60. [Expense incurred for any service, treatment or supply for the diagnosis or treatment of sexual dysfunction (including erectile dysfunction). This includes, but is not limited to, drugs [except as noted], laboratory and x-ray tests, counseling, transsexual procedures or penile prostheses necessary due to any medical condition or organic disease. A penile prosthesis will be eligible for payment only after prostate surgery; [Doctor-prescribed Viagra will be limited to six (6) tablets per month];]

61. [Illegal drugs;]

62. [Medicines not taken in the dosage or for the purpose prescribed by the Insured Person's Doctor;]

63. [Expense incurred for: topical acne treatments, moles, non-malignant warts or lesions, fertility medication; legend vitamins or food supplements; smoking deterrents; immunization agents; biological sera; drugs to promote or stimulate hair growth; experimental drugs; drugs dispensed in a rest home or hospital, except as provided under the Hospital Expense Benefit;]

64. [Expenses incurred for any experimental drug or drug combination which the Federal Food and Drug Administration (FDA) has not approved for any indication, or for any drug which the FDA has determined to be contraindicated for a particular condition;]

65. [Testing, treatment, or services for any condition in the absence of Sickness or Injury except as specifically provided;]

66. [Expenses incurred for replacement braces and appliances, except for repair or replacement that is required by a changed condition due to Sickness or Injury;]

67. [Spinal manipulation, including adjustment and other chiropractic-type services;]

68. [Alternative health care, including (but not limited to) acupuncture, except as specifically provided, acupressure, biofeedback, reflexology, and rolfing type services;]

69. [Expenses incurred for services or supplies for the diagnosis and treatment of sleep disorders, including but not limited to apnea monitoring and sleep studies;]

70. [Hearing aids, including exams for fitting, except as required to correct damage caused by an Injury which occurs while the patient is covered by this Plan, provided they are obtained within four months of the date of the Injury;]

71. [Services, supplies and facility that are provided mainly for a rest cure, maintenance or custodial care;]

72. [Expense for hair replacement, wigs or wig maintenance;]

73. [Services that have already been paid by another insurance carrier, even if those services would have otherwise been covered by this Plan;]

74. [Any treatment, service or supply in excess of the maximum benefit specified in this Policy;]

75. [Care, treatment or supplies furnished by a program or agency funded by any government;]

76. [Hospital inpatient admissions primarily for diagnostic studies when bed care is not Medically Necessary;]

77. [Professional services billed by a Doctor or nurse who is an employee of a hospital or skilled nursing facility, and who is paid by that facility for the service;]

78. [Nicotine addiction;]

79. [Patient controlled anesthesia.]

Limitation for Pre-Existing Conditions
We [will not pay *or* will pay up to {$500 to $2,500} of] benefits for any expenses Incurred for treatment of an Insured Person's Pre-Existing Condition until he has been insured under this Policy;

1. if he enrolled for coverage within {30} days after he first became an Eligible Person, a continuous period of 12 months; or
2. if he enrolled for coverage more than {31} days after he first became an Eligible Person, a continuous period of 18 months.

Any period during which benefits are not payable for a Pre-Existing Condition will be reduced by the number of months during which the Insured Person was insured by another similar health care plan under which coverage ended not more than 60 days before he became insured under this Policy. This 60-day period will be extended by the number of days in any applicable Waiting Period shown in the *Schedule of Benefits*, as long as the Eligible Person has completed any required enrollment before the end of the Waiting Period.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES. The entire contract is made up of: (a) this Policy, including Your Application; and (b) the individual applications, if any, of Insured Persons. Statements made by the Policyholder, Policyholder or an Insured Person shall be deemed to be representations and not warranties. No such statement may be used in any contest of this insurance, unless the statement: (1) is contained in writing and signed by the applicant; and (2) a copy has been given to such person, or to his/her beneficiary. No change in this Policy shall be valid unless approved by an officer of Ours. It must be evidenced by endorsement on this Policy, or by amendment of this Policy signed by the Policyholder and Us. No agent has authority to change this Policy or to waive any of its provisions.

GRACE PERIOD. A grace period of thirty-one days will be granted for the payment of each premium falling due after the first premium. During that period, this Policy shall continue in force. You shall be liable to Us for the payment of the premium for the period this Policy continues in force.

NOTICE OF CLAIM. Written notice of claim must be given to Us within {30} days after the occurrence or commencement of any Loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant or the beneficiary to Us at Our Administrative Office or to any authorized agent, with information sufficient to identify the Insured Person, shall be deemed notice to Us.

CLAIM FORMS. Upon receipt of a written notice of claim, We will give the claimant such forms as are usually given by Us for filing proof of Loss. If such forms are not given within 15 days after receipt of such notice, he or she can fulfill the terms of this Policy as to proof of Loss by giving written proof of: (a) the occurrence of the Loss; (b) the nature of the Loss; and (c) the extent of the Loss.

PROOF OF LOSS. Written proof of Loss must be given to Us at Our Home Office within **{**90} after the date of such Loss. Failure to give such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, proof must be given as soon as reasonably possible and in no event later than one year.

TIME PAYMENT OF CLAIMS. Benefits payable under this Policy shall be paid as they accrue and as soon as due written proof of such Loss has been received by Us.

PAYMENT OF CLAIMS. All benefits for Loss other than death, will be paid to the Insured Student. All or a portion of the benefits, if any, provided by this Policy may be paid directly to the Hospital or person rendering such services. It is not required that the service be rendered by a particular Hospital or person. The Insured Person must make a written request to Us before We can do this. We must receive the request no later than the time for filing proof of Loss. Death benefits, if any, will be paid to the beneficiary chosen by the Insured Student. This choice must be in writing and filed with Us. If the Insured Student has not chosen a beneficiary, or if there is no beneficiary alive when the student dies, We will pay:

(a) his/her parents or legal guardian, if a minor;
(b) otherwise, We will pay his/her estate.

Benefits payable under the Policy to the Insured Student will be paid with or without an assignment from the Insured Student, to public Hospitals or clinics for services and supplies provided to an Insured if a proper claim is submitted by the Public Hospital or clinic. No benefits will be paid under the Policy to the public Hospital or clinic if such benefits have been paid to the Insured Student prior to Our receiving the claim. Payment of benefits to such public Hospital or clinic will discharge Us from all liability to the extent of any such payment.

We will pay these benefits immediately upon receipt of due written proof of such Loss.

Covered Charges paid on behalf of an Insured Person will be paid to the human services department when:

(a) the human services department has paid or is paying benefits on behalf of such person under the State's medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.;
(b) payment for the services in question has been made by the human services department to the medicaid provider; or
(c) We are notified that such person receives benefits under the medicaid program and that benefits must be paid directly to the human services department.

PHYSICAL EXAMINATION. At Our own expense, We have the right to have a Doctor examine an Insured Person when and so often as We deem reasonably necessary while there is a claim pending under this Policy. We have the right to conduct an autopsy in case of death where it is not prohibited by law.

LEGAL ACTIONS. No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the Policy and that no such action shall be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Policy

RECORDS MAINTAINED. You shall maintain records of each person insured. The records shall show all data that is needed to administer this Policy.

EXAMINATION AND AUDIT. We shall be allowed to examine and audit Your books and records which pertain to this Policy at reasonable times. We may also be allowed to do this within three (3) years after the later of: (a) the date this Policy terminates; or (b) until final settlement of all claims hereunder.

CERTIFICATES OF INSURANCE. Where required by law, a certificate of insurance will be delivered to the Policyholder for delivery to each Insured Student. The certificate will list the benefits, conditions and limits of the Policy and will state to whom benefits will be paid.

[CONFORMITY WITH STATE STATUTES. Any provision of this Policy which, on the Policy Effective Date, is in conflict with the statutes of the state in which the Insured Person resides on such date, is hereby amended to conform to the minimum requirements of such statutes.]

[PREMIUM REFUND POLICY. If an Insured Student withdraws from the university within the first {ten (10)} days of the first semester, and has not yet submitted a claim, he or she will receive a full refund of the insurance premium. If an Insured Student withdraws from the university after{ten (10)} days of the first semester, his or her coverage will remain in effect until the end of the term for which he or she was charged premium. If the Insured Student withdraws: (a) other than due to entering any military service; and (b) after the first {ten (10)} days of the semester, no premium refund will be made.

Those Insured Students withdrawing from school to enter military service will be entitled to a pro-rata refund of premium upon written request of the withdrawal from school, and coverage will end as of the date of such entry.]

[The Insured Person may cancel their coverage with {ten (10)} working days of the Effective Date of coverage by submitting a request for cancellation in writing to the university. Under no circumstances will a cancellation refund be provided if the Insured Person has filed a claim with Us.]

COORDINATION OF BENEFITS

This section will be used to determine an Insured Person's benefits under this Policy IF:

the Insured Person is insured for medical care benefits under this Policy and is also covered for these benefits under other Plans,
and
the benefits that would be paid by this Policy, without this section
PLUS
the benefits that would be paid by the other Plans, without a section similar to this section
WOULD EXCEED ALLOWED EXPENSES as defined below.

DEFINITIONS:

PLAN means a plan which provides benefits or services for, or by reason of, hospital, surgical, medical, or dental care or treatment through:

1. group, blanket or franchise insurance coverage; this does not apply to blanket school accident only coverages;

2. pre-paid plans for:
   - group hospital service;
   - group medical service;
   - group practice;
   - Individual practice; and
   - any other such plans for members of a group;
3. any plan provided by:
   - labor management trusts;
   - unions;
   - employer organizations;
   - professional organization; or
   - employee benefit organizations;
4. a government program, or statute, other than a state medical assistance plan that implements Title XIX of the Social Security Act of 1965;
5. any group or group type hospital indemnity of more than $200.00 per day;
6. Medicare (Title XVIII of the Social Security Act); and
7. any part of a state auto reparation or indemnity act (no fault insurance) with which the state permits coordination.

Plan does not include individual or family policies; individual or family subscriber contracts except as stated. Nor does it include any group or group type hospital indemnity or medical payment benefits customarily included in the traditional automobile contracts.

THIS PLAN means the medical care benefits provided by this Policy.

ALLOWED EXPENSE means an expense which is:
- necessary, reasonable and customary;
- incurred while the person (for whom the claim is made) is insured, or is entitled to benefits after insurance ends, under this Policy; and
at least partly covered under one of the plans covering such Insured Person.

When this plan does not pay its benefits first, Allowed Expense will not include an expense which is not paid because of the claimant's failure to comply with the cost containment requirements of the plan which pays its benefits first.

When a plan provides a benefit as a service rather than a cash payment, the reasonable cash value of the service will be considered to be both an allowed expense and a benefit paid.

EFFECT ON BENEFITS UNDER THIS PLAN

When this section is used, the rules listed below will determine the amount of benefit each plan will pay. All benefits will be determined on a calendar year basis.

These rules may require this plan to pay its benefits first. If so, this plan will pay its full benefits without taking into account other plan benefits. These rules may require one or more of the other plans to pay their benefits before this plan. If so, this plan will reduce its benefits so that in any calendar year, the sum of all benefits to be paid to a person (by this and all other plans) equals the allowed expenses for that year. Benefits to be paid under other plans include benefits that would be paid if proper claim is made for such benefits.

RULES TO DETERMINE WHICH PLAN PAYS FIRST

A plan, or part of one, that does not have a section similar to this section will pay its benefits before a plan that has such a section.

In all other cases, the plan that will pay its benefits first will be:

1. The plan which covers the Insured Person as an employee rather than as a full or part-time student. Item 1 will not apply unless a similar provision is contained in all plans. In this case item 2, 3 or 4 will determine which plan pays first.
2. If 1 does not apply, the plan which covers the person as a full or part-time student rather than as a dependent.
3. If 1 and 2 do not apply, the plan which covers the person as a dependent of the parent whose month and date of birth occurs earlier in the year. If the other plan has a rule based on the gender of the parent, the gender rule will determine the order of benefits. However, a child's parents may be divorced or separated. If so, the plan to pay its benefits first will be the plan which covers the child as a dependent of the parent with custody rather than as a dependent of the parent without custody. If the parent with custody remarries:
   - the plan which covers the child as a dependent of a parent with custody will pay its benefits first;
   - the plan which covers the child as a dependent of a stepparent will pay its benefits next; and
   - the plan which covers the child as a dependent of a parent without custody will pay its benefits last.

A court decree may require the parent without custody to be financially responsible for the child's health care. If so, the plan to pay its benefits first will be the plan which covers the child as a dependent of the parent with such responsibility rather than as a dependent of any other person.

4. If 1, 2, or 3 do not apply, the plan which has covered the insured person for the longer time rather than the shorter time.

If the benefits of this plan are reduced due to these rules, such reduction will be done in proportion. Any benefits paid by this plan on a reduced basis will be charged against the benefit limits of this plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For this section to work, We must exchange information with other plans. To do so, We may give to, or get from any source all such information necessary. This will be done without the consent of or notice to any person. Any person claiming benefits under this plan must give to Us the required information.

FACILITY OF PAYMENT

Another plan may pay a benefit that should be paid by Us by terms of this section. If this happens, We may pay to such payor the amount required for it to satisfy the intent of this section. This will be done at Our discretion. Any amount so paid will be considered a benefit under this plan. We will not be liable for such payment after it is made.**]**

[**APPEALS PROCEDURE**

If a claim is wholly or partially denied, a written notice will be sent to the Insured Person containing the reason for the denial. The notice will include a reference to the provision in the Plan description and a description of any additional information which might be necessary for reconsideration of the claim. The notice will also describe the right to appeal. A written appeal, along with any additional information or comments, may be sent within 6 months after notice of denial. In preparing the appeal, the Insured Person, or his or her representative, may review all documents related to the claim and submit written comments and issues related to the denial. After the written notice is filed and all relevant information is presented, the claim will be reviewed and a final decision sent within 60 days after receipt of the notice of the appeal. Under special circumstances, an extension for further review will be granted, but not for longer than 60 additional days.]

[EXCESS AND PRIMARY EXCESS] PROVISION

[EXCESS PROVISION

No benefit under this Policy is payable for any Expense incurred for Injury or Sickness which is paid or payable by other valid and collectible insurance except under an automobile insurance policy.

Covered Medical Expenses exclude amounts not covered by the primary carrier due to penalties imposed on the Insured Person for failing to comply with policy provisions or requirements.**]**

[PRIMARY EXCESS PROVISION

[After We pay an initial amount as shown in the *Schedule of Benefits*, no benefits in excess of this initial amount are payable under this Policy for any Expense incurred for Injury or Sickness which is paid or payable by other valid and collectible insurance except under an automobile insurance policy.]

[This Plan of insurance is primary for Student Health Center charges. Otherwise this Plan of insurance is secondary to any benefits paid or payable by other valid and collectible insurance, except under an automobile insurance policy. Benefits paid or payable by other valid and collectible insurance include benefits that would have been received had a claim for benefits been duly made therefor.]

Covered Medical Expenses exclude amounts not covered by the primary carrier due to penalties imposed on the Insured Person for failing to comply with policy provisions or requirements.**]]**